Maternal and Child Health Services
Title V Block Grant

State Narrative for District of Columbia

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

These documents are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Needs Assessment
There were several components to the Title V Needs Assessment: a contracted service to conduct quantitative data analysis, key informant interviews and focus groups to assess Maternal and Child Health needs in the District;

A Community Forum was convened on April 6, 2010, to seek stakeholder input on preliminary data gathered from the 2010 Needs Assessment in order to help rank DC Maternal and Child Health priorities. More than 60 participants attended, representing parents, providers, advocates, community organizations and government agencies. .Dr. Anjali Talwalkar opened the session with a welcome and overview of the Title V grant including objectives, funding requirements and current programs supported through Title V funds. The contractor, InterGroup Services, then presented an overview of the needs assessment process undertaken (the methodology is described in the attached needs assessment document) and shared key quantitative and qualitative findings. Participants were then asked to select a specific focus group to attend for more in-depth discussion and debate of potential priorities: Children/Youth with Special Health Care Needs, Child and Adolescent Health, or Perinatal and Maternal Health. The entire group was re-convened after the breakout sessions to rank priorities. The priorities that emerged from the Community Forum were the following: unintended pregnancies/teen births; decrease infant mortality; increase knowledge of available services; improve special health care needs diagnosis in schools; improve access to medical services; enhance nutrition/physical activity; increase recreational programs for youth; increase access to medical homes for CSHCN; increase access to prenatal care; and increase home visiting programs.

To supplement the Contractor's needs assessment efforts, CHA also utilized a variety of other mechanisms to identify Maternal and Child Health needs in the District and to gather input from community partners to help inform priority-setting, including multiple District-wide forums and several additional sources of data such as the Rand Corporation's 2009 Report Health and Health Care Among District of Columbia Youth, the National Survey of Children with Special Health Care Needs 2005/2006, the CDC's Breastfeeding Survey and the National Alliance to Advance Adolescent Health needs assessment.

Ongoing Communication with the Public
The Title V Needs Assessment and priority list will be found on the Title V website, a part of the CHA website off the DOH main page (http://doh.dc.gov/doh/site/default.asp).

The Office of the Deputy Mayor for Education continues to hold focus groups around children and youth health, education and development. Fall 2010, Children's National Medical Center is hosting three citywide Pediatric Forums for leaders throughout the District to come together to share resources and tackle pediatric issues collaboratively. Representatives from the Department of Health and the Title V program will participate in all these gatherings to promote Title V programs and services and to solicit feedback. The Title V program also convenes and participates on several advisory groups and committees to share information about maternal and child health programs and practices, including the Advisory Board for Children with Special Health Care Needs; the Advisory Committee for Perinatal, Infant and Interconceptional Health and Development; the DC Home Visiting Council; and the DC Council on Young Child Wellness. Town Hall meetings and focus groups are periodically convened to address specific MCH topics and are comprised of parents, advocates, adolescents, providers, and agency representatives for children and youth with special needs. CHA receives and reviews minutes and reports from these forums, using this information to support program decisions. For example, the Advisory Committee for Perinatal, Infant and Interconceptional Health and Development was instrumental in guiding the PIHB's social marketing campaign "I am a Healthy DC Mom."

DOH is working on a single Action Plan for DC that will be ready in Summer 2011 which will include the Title V action Plan. DOH is also working on completing Ward Level profiles that will be gender specific.
DOH has begun using Twitter and Facebook as social marketing tools which will be explored to enlighten the public about the priorities and funnel information about DOH programs out to the public, along with Photo Novellas; ethnic specific ads are currently used on the programmatic level to communicate with the public

An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Title V Maternal and Child Health (MCH) Services Block Grant requires states and the District of Columbia to complete a comprehensive needs assessment every 5 years to determine gaps in health status and health system capacity for the maternal and child health (MCH) population. The assessment includes research of public health and other data, summaries of state and local stakeholders, and assessment of the state system's ability to deliver interventions and programs effectively.

InterGroup Services (IGS) was awarded the contract to perform the needs assessment. IGS has performed similar work for Prince George's County Commission on Children, Youth, and Families and an assessment of the Needs of Toddlers and Young Children in Baltimore County. Mary Frances Kornak was the DOH Contracting Officer's Technical Representative (COTR). The scope of work includes an assessment of internal MCH capacity through the CAST V Capacity Assessment Tool. Key informant interviews and focus groups with consumers, stakeholders, and organizations comprised the community assessment component of the needs assessment that will discuss needs, problems, and solutions to access the health of the MCH population.

Various methods of data collection were utilized in completing this needs assessment. Some were quantitative, such as examining health care trends and reports or MCH-related survey results, while others were qualitative, such as conducting key informant interviews and focus groups with District residents who use Title V services or those who work in the MCH field. The Department of Health (DOH) and its contractor IGS identified and contacted organizations involved in MCH. IGS asked representatives of each organization to assist in identifying and recruiting participants from its client ranks for focus groups to be convened. DOH developed a list of MCH experts whom IGS interviewed. IGS asked these "key informants" questions previously devised in consultation with DOH. Interviewees represented large national organizations and hospitals as well as small grassroots outfits.

Using the nine community-level priorities identified in the 2005 Title V needs assessment, an analysis was undertaken this year to determine the status of these health issues in the District. Additional important indicators of maternal and child health were also analyzed to guide identification of priorities for Title V programs to address over the next five years.

Ten focus groups were held throughout the District, eight community focus groups and two groups for MCH professionals identified by email lists, word of mouth, and associations like the CSHCN advisory board. Over 100 individuals contributed their opinions on the status of Title V services in the District. In addition, key informant interviews were conducted over the phone with 10 MCH experts working in the District.

Both group participants and key informants were asked to identify the services/initiatives that they felt were the most successful for the MCH population, focusing on the subpopulations: Pregnant Women /Mothers/Infants, Children and Youth, and Children with Special Health Care Needs.

A CAST V assessment conducted by Holly Grason and IGS was used to access the internal capacity of the MCH bureaus and programs to identify their current resources, activities, and services as well as their ability to continue to provide and to enhance services from each of the pyramid levels. It is recommended that CHA adopt "formal protocols and guidance for all aspects

of assess¬ment, planning and evaluation cycle" as its infrastructure priority and develop an action plan to implement this priority over the next five years.

Suggestions for disseminating information about available services included the publication of a free, printed service directory that would be available at health centers, libraries, and near public transportation access areas. Media campaigns were also noted as a way to effectively advertise to the public. Participants suggested that in addition to being used to make families aware of available services, media campaigns should also be used to eliminate stigma regarding STDs and other issues that are often misunderstood by the community, especially youth.

There are several ongoing initiatives underway in the District to address maternal and child health needs and facilitate coordination of efforts. These initiatives bring together community leaders from neighborhoods, local organizations, clinical institutions, and government agencies to share ideas and formulate strategies to better coordinate services. The Statewide Commission on Children, Youth and Families consists of leaders of District government agencies. SEE THE ATTACHED NEEDS ASSESSMENT EXECUTIVE SUMMARY.

The final State priorities for DC were determined through analysis of the information compiled from various sources. The ranked list of priorities from the Community Forum served as the starting point. Upon closer examination of the list, many of the top ten priorities were determined to be intermediate outcomes towards addressing an overarching primary priority. For example, recommendations to increase access to prenatal care and home visiting programs are also strategies to decrease infant mortality, so CHA decided to select infant mortality as the priority with the knowledge that prenatal care and home visiting are potential intervention areas to address that need. Priorities from the Community Forum list were also modified to better reflect what the Department of Health (DOH) has more authority to influence.

Based on its review and evaluation of the Needs Assessment document CHA is considering a review in the next 3 years.

DOH is also working on a single Action Plan for DC that will be ready in Summer 2011 which will include the Title V action Plan.
An attachment is included in this section.

III. State Overview

A. Overview

The District has a unique status as the nation's capital and serves the multiple roles of a city, county and state. It consists of an urban land area of 63 square miles. Fifty-seven percent of the land base is tax-exempt, much of it owned by the federal government, and 41% of the assessed property value is exempt from property taxes, factors that impact upon the resources available to the District government for services to residents. Although DC residents elect a mayor and city council, they do not have voting representation in the US Congress, which has exclusive authority over legislative acts, including those pertaining to the budget. This status, combined with limitations of the local government's authority to tax federal and other property and incomes of commuters, severely limits the availability and allocation of resources.

The District's population has been growing steadily since 2000 with the most recent Census Bureau estimate in 2009 to 599,657. In 2008, the population distribution was 54.4% African American, 40.1% Caucasian, 8.2% Hispanic, 5.1% includes Native Americans, Alaskans, Hawaiians, and Pacific Islanders, 3.4% Asian, and 1.5% mixed (two or more races). The 2006 American Community Survey found that only 40% of current D.C. residents were born in the District, 16% below the national average.

District residents live in one of the eight Wards. Economic disparities are evident among all the wards. For example, Wards 6, 7, and 8 comprise the majority of African American residents (79.2%) and more than 30% live below the Federal Poverty Level (FPL). Wards 4 and 1 comprise a significant proportion of the Latino population (20.8%) with expansion into Wards 5 and 6, due to rapid economic development.

The Rand Study (January 2008) reported that health outcomes in adult District residents varied significantly across wards. 1) Ward 7 had the highest rates of hypertension, diabetes, any chronic condition, and poor or fair self-reported health. These rates were statistically higher than the mean rate for all of DC. 2) Rates of hypertension, diabetes, and overweight/obesity were also higher in Ward 8 compared to the city-wide average. 3) Ward 5 had higher rates of hypertension and overweight/obesity compared to the citywide average. 4) The highest rate of obesity was in Ward 8. Rates of obesity were higher in Wards 4, 5, 7, and 8 compared to the city as a whole. Nearly three out of every four adult Ward 8 residents reported a height and weight that classifies them as overweight. Among key findings related to nutrition, physical activity and obesity for children in the District overall are the following: 1) Seven percent of children were reported to have a health issue that limits their ability to perform the activities of most children. 2) Across the city, 36 percent of children between ages 6 and 12 were overweight, while 17 percent of children between ages 13 and 17 were overweight. The Rand Study reported that 4.1% of District parents report that their children have poor or fair health and 12.1% believe that their children require more medical care than other children.

About one-third of Washington residents are functionally illiterate (DC LEARNS August 2007 issue), compared to a national rate (one in five). This is attributed in part to Hispanic, Ethiopian, and Eritrean immigrants that make up 12.7 percent of the District's population but are not proficient in English. It is also important to note that 45 percent of D.C. residents have at least a four-year college degree, the fourth-highest rate in the nation, illustrating the social divide present in the city.

The health and well being of women and children in shelters, transitional homes and on the street continue to be a major concern of the DOH. The Community Partnership for the Prevention of Homelessness (CPPH) reports on behalf of the District of Columbia the Annual Homeless Assessment Report (AHAR) for the Department of Housing and Urban Development (HUD). The purpose of the data reporting is to identify gaps in services, understand the nature of homelessness and analyze Continuum of Care effectiveness and utilizations. In January 2008

CPPH reported the age distribution of the 11,562 individuals in shelters for the period from October 2006 - September 2007 as: Ages 13-17 (.03%); 18-30 (8.0%); 31-50 (39.6%), 51-60 (18.8%) and 62 and older (3.8%). The District of Columbia Homeless Services Reform Act (2005) redefined Hypothermia and Emergency Shelter as Severe Weather and Low Barrier Shelter to ensure that the District's homeless population had access to shelter in the event of severe weather, such as extreme hot and cold temperatures, flooding and high winds.

The breakdown of single persons in the shelter system was 17 percent women and 83 percent men with a median length of stay at emergency shelters of 20 days. Twelve percent (12%) of homeless women and eight percent (8%) of homeless men stayed in shelter the entire year. One in ten persons in emergency shelter reported disabilities.

The number of families in the Emergency Shelter System was 1,661 persons in 507 families that were served in publicly funded emergency shelters in FY07; 1,008 of the persons served were children, accounting for 61 percent of the population and 77 percent of adult persons in families were female. The median length of stay for adults in family emergency shelter was 160 days; 20 percent of families served in FY07 were in shelters for the entire year and 40 percent of the adults in families served were living with family or friends before entering a shelter. Families in Transitional Housing accounted for 769 persons in 256 families that were served in publicly funded transitional housing for families in FY07; 480 of the persons served were children, or 62 percent; 89 percent of the adult persons in families were female. The median length of stay for adults in family transitional housing was 361 days; 53 percent of families served in FY07 were in shelters for the entire year. On an average night during the period, 75 percent of family transitional housing beds were occupied.

According to the DC Office of Planning's 2007 American Community Survey, the District had 13% of all its families in the past 12 months below the poverty line with 19.1% with related children under 18 years of age and 8.2% with related children under 5 years of age. It also stated that 26.9% of the District households did not have a husband present.

The District is broken down into eight wards based upon zip codes, boundaries, census tract and Council representation. Economic, social and health status indicators vary considerably across the 8 wards. The following is a summary of the health and socioeconomic profile of the 8 wards from the DC Department of Health State Center for Health Statistics, Center for Policy, Planning and Evaluation.

- Ward 1, a racially and ethnically diverse community, is centrally located in the heart of the District of Columbia. The majority of Ward 1 residents are working-aged adults who are employed in the civilian sector. Over 90% of Ward 1 residents possess some type of health care coverage. Over 66% of the population obtains health screenings for HIV and Cancer. Major health challenges include relatively high death rates due to essential hypertension and prevalence of HIV/AIDS. Health risk behaviors include obesity and binge alcohol consumption.

- Ward 2 is bordered by the Potomac River to the west and is located primarily in the southwestern section of the District of Columbia. A racially and ethnically diverse community, the majority of its residents is working aged adults who are employed in the civilian sector. In the area of health care access, almost 95% of Ward 2 residents possess some type of health care coverage. Over 70% of residents have received screening for breast or prostate cancer. Major health challenges include the relatively high death rates due to essential hypertension and HIV/AIDS. Upon examination of health risk behaviors, over 90% of Ward 2 residents are engaging in some physical exercise and over 55% are maintaining a healthy weight. However, a comparatively high number are consuming dangerously high amounts of alcohol. A relatively high percentage (12%) of Ward 2 residents reported having physician diagnosed asthma.

- Ward 3 is located in the northwestern section of the District of Columbia. The community has a majority white population (80%) with a population of Blacks and Hispanics slightly above

6%. Almost 80% of Ward 3 residents have attained Bachelor's degree level education or higher. In the area of health care access, over 95% of Ward 3 residents possess some type of health care coverage. Over 78% of residents have received screening for breast or prostate cancer. Major health challenges include the relatively high death rates due to heart disease and essential hypertension.

- Ward 4 is located in the northernmost tip of the District of Columbia. A predominantly African-American community with a growing Hispanic population, the majority of its residents is working-aged adults who are employed in the civilian sector. In the area of health care access, about 93% of Ward 4 residents possess some type of health care coverage. While over 85% of residents have been screened for breast cancer, only 57% have been screened for prostate cancer. HIV screening has been conducted for over 70% of the Ward 4 population. Major health challenges include the relatively high death rates due to heart disease, cancer and essential hypertension.

- Ward 5 is located in the northeastern quadrant of the District of Columbia. A predominantly African-American community, the majority of its residents is working-aged adults who are employed in the civilian sector. In the area of health care access, about 85% of Ward 5 residents possess some type of health care coverage. Over 82% of female residents have been screened for breast cancer and over 72% of male residents have been screened for prostate cancer. HIV screening has been conducted for over 73% of the Ward 5 population. Major health challenges include the relatively high death rates due to heart disease, cancer and essential hypertension. Homicide is the sixth leading cause of death among Ward 5 residents.

- The boundaries for Ward 6 cross all four quadrants of the District of Columbia. A racially diverse community with a growing Hispanic population, the majority of its residents is working-aged adults who are employed in the civilian sector. In the area of health care access, about 91% of Ward 6 residents possess some type of health care coverage. While over 82% of female residents have been screened for breast cancer, only 68% of male residents have been screened for prostate cancer. HIV screening has been conducted for over 71% of the Ward 6 population. Major health challenges include the relatively high death rates due to heart disease, cancer and essential hypertension. A health risk of concern is the relatively low percentage of persons within a healthy weight range.

- Ward 7 is located in the eastern most tip of the District of Columbia. A predominantly African-American community, almost 30% of the population is 19 years old or younger. In the area of health care access, about 86% of Ward 7 residents possess some type of health care coverage. Approximately 78% of female residents have been screened for breast cancer and over 67% of male residents have been screened for prostate cancer. HIV screening has been conducted for over 70% of the Ward 7 population. Major health challenges include the relatively high death rates due to heart disease, cancer, diabetes and essential hypertension. Homicide is the fifth leading cause of death. Health risk behaviors of concern include obesity, lack of physical activity and current smoking.

- Ward 8 is located in the southern most tip of the District of Columbia. A predominantly African-American community, almost 40% of the population is 19 years old or younger. In the area of health care access, about 88% of Ward 8 residents possess some type of health care coverage. Approximately 77% of female residents have been screened for breast cancer and over 67% of male residents have been screened for prostate cancer. HIV screening has been conducted for over 80% of the Ward 8 population. Major health challenges include the relatively high death rates due to HIV/AIDS and essential hypertension. Homicide is the fourth leading cause of death. Health risk behaviors of concern include obesity, lack of physical activity and current smoking.

The District has seven birthing hospitals and one birthing center that provide obstetrical and/or neonatal services, four of which provide tertiary care for deliveries and neonates: Georgetown

University Hospital (tertiary), George Washington University Hospital (tertiary), Washington Hospital Center (tertiary), Howard University Hospital (tertiary), Providence Hospital, Sibley Hospital, United Medical Center and DC Birth Center. The District also has 30 Community Health Centers and 48 Primary Care Health Centers.

The three Managed Care Organizations (MCOs) are mandated to provide case management services to high-risk pregnant women. These women are only identified for services after they have presented to a provider for care and therefore are sometimes missed for referral for case management.

Presently there are three Healthy Start programs in the District. Two of the programs are overseen by the Department of Health and the remaining program is managed by Mary's Center, a Federally Qualified Health Center that provides primary care and enabling services to underserved and underinsured immigrants primarily from Latin America, the Caribbean, Africa, the Middle East, and Asia. These programs provide outreach and client recruitment, case management and health education to the District's high risk pregnant and postpartum women and their infants. Even though services are available to promote healthier birth outcomes, some of the Districts residents and medical providers do not have information about these services. This is thought to be a result of the transiency of the District's residents and provider turnover.

Fortunately, the District has an MCH administrator, department colleagues, collaborators and the city council who keep their fingers on the pulse of the city and who recognize the importance of convening public meetings with stakeholders to collect input and develop effective strategies for program and policy implementation. Emerging issues for the city which will impact Title V include: 1) the impact of new health care reform initiatives which will expand access to health insurance programs for District residents; 2) a high incidence of sexually transmitted infections (STI) among youth requiring enhanced STI prevention and primary care; 3) pediatric health issues related to overweight/obesity; and 4) increasing youth violence and truancy. The District is evaluating a host of strategies to address this latter issue, including the possibility of early, targeted mental health interventions and services, the expansion of high school based health centers (medical homes); juvenile justice reforms, and increased accountability for parents and guardians. The most recent efforts to address the needs of District residents that will support and enhance the efforts of the Title V grant include: 1) In 2010 the District will add three new high school based health centers bringing the total to five (5). 2) The Youth Sexual Health Project is a new priority requiring coordination with District of Columbia Public Schools, District Department of Environment, Department of Youth Rehabilitation Services, District youth, and community-based providers to implement the Project's recommendations. 3) The National Institutes of Health announced the new D.C. Partnership for HIV/AIDS Progress, a collaborative research initiative between NIH and the Department of Health designed to decrease the rate of new HIV infections in the city, improve the health of District residents living with HIV infection, and strengthen the city's response to the HIV/AIDS epidemic. The partnership is being co-led by the National Institute of Allergy and Infectious Diseases (NIAID), part of NIH, and the D.C. Department of Health. 4) DOH has launched the Live Well DC campaign (LWDC), an interagency effort to create a holistic approach to health and wellness by targeting individual behaviors that result in poor health outcomes. LWDC aims to improve the health of those in our community, and ensure that District residents live longer, more productive lives by encouraging residents to follow 10 Healthy Living Tips. 5) The city also recently purchased United Medical Center, the only hospital serving residents east of the Anacostia River to ensure continued access to health care. 6) The DC HomeVisitation Councill has been rejuvindated and DOH is an active participant.

An attachment is included in this section.

B. Agency Capacity

The Community Health Administration (CHA) is the administration within the DC Department of Health (D0H) that administers the Title V Maternal and Child Health Block Grant. The mission of

the administration is to improve health outcomes for targeted populations by promoting coordination across systems of care; by enhancing access to prevention, medical care and support services; and by fostering public participation in the design and implementation of programs for District of Columbia women, infants, children (including children and youth with special health care needs) and other family members. Consequently, while Title V does not fund all activities within the administration, many of its programs touch the MCH population, and where appropriate, program linkages are made to maximize the benefit to this population.

The DOH's capacity to provide preventive and primary care services for pregnant women, mothers, infants, children, including children and youth with special health care needs, is evidenced in its policies, programs, and grants and collaborations with government and agencies. Key partnerships emerge from the existing networks of agencies, groups, organizations and individuals who are already involved in maternal and child health work. CHA has developed strong partnerships with other District government entities such as the local Public School System, the Department of Health Care Finance who oversees Medicaid for the District, the Department of Parks and Recreation, the Child and Family Services Agency, the Department of Mental Health, and the Department of Human Services to name a few. These partnerships have also been extended to local colleges and universities as well as community-based youth service agencies. The synergy that exists among these entities serves to integrate services and systems for adolescents and youth to avoid duplication of resources and to ensure that District of Columbia youth are healthy and able to succeed. For example, the Department of Human Resources funds school-based programs for pregnant/parenting teens in DC Public Schools. The Department of Health Title V program funds clinic-based programs for pregnant/parenting teens at major hospital centers such as Children's National Medical Center and Washington Hospital Center. The collaboration of agencies ensures that the school-based and the clinic-based programs also collaborate so pregnant/parenting teens receive coordinated, comprehensive care.

Staff in the Perinatal and Infant Health Bureau and the Child, Adolescent and School Health Bureau actively partners with other local youth organizations and providers to co-sponsor events and to assure that youth have access to needed services and opportunities within their communities (e.g., legal services; tutoring and academic support; entrepreneurship; mental health counseling; school health services, youth development, physical activity, socialization, mentoring and related services.) PIHIB wriote a white paper on Home Visiting.
Grants have been submitted on first time motherhood and teen pregnancy, as well as a planning grant to the Officce on Women's Health. The Coalition for Healthier Families developed an action plan to do focused studies in Wards 7&*; subcommittees are also woking on issues for women and girls.CHA is alsoopening 3 new school based healh centers.

The reorganization of Community Health Administration in FY 2008 presented some unique opportunities to examine program effectiveness, identify gaps in services and develop mechanisms to ensure programs and services were in place for CSHCN transitioning from childhood to adolescence. The Perinatal and Infant Health Bureau (PIHB) expanded its services to include the management of Newborn Hearing Screening and Newborn Metabolic Screening programs. Along with the DC Healthy Start program, these additional programs decreased resource duplication and improved identification of children 0 -- 3 years of age who are at risk for developmental delays or physical deficits. Once a problem is identified, that child is referred to Early Intervention, located in the Office of the State Superintendent of Education (OSSE). They in turn ensure that parents with a referred result on the hearing or metabolic screening are referred to the DC Healthy Start program. Once a child ages out of PIHB programs, they are referred to the CASH Bureau, as needed. The responsibility that each Bureau holds for Children and Youth with Special Health Care Needs and the coordination between the Bureaus reflects the importance of providing continuous, coordinated services from infancy to adulthood. Dr. Talwalkar meets with both Bureau Chiefs on a bi-weekly basis to discuss program and operational issues. Additionally, the PIHB and CASH program teams collaborate at least monthly

to discuss and coordinate child services and programmatic issues. These two Bureaus also meet quarterly with other District agencies to identify, discuss and help resolve barriers to care for children and youth with special health care needs and their families via the CYSHCN Interagency Committee.

Each CHA employee is required to participate in cultural awareness training and requires that each of its sub grantees meet cultural awareness and competency requirements. The District meets the OMB requirements for culturally competent care based on its MCH populations. CHA includes representatives from the Latino, Asian Pacific Islander and Sub Saharan African communities to participate in Advisory Boards, focus groups and town hall meetings, and it has awarded sub grants for MCH programs. DOH provides telephone-based medical and social translation services to any person seeking information and/or services. In addition, the District supports medical translation certification programs offered by a community-based clinic.

Each of CHA's Bureaus is focused on the cultural and linguistic needs of the District's maternal and child population, including children and youth with special health care needs. A description of each of the Bureaus is presented in the Organizational Structure section that follows. The staff supports culturally and linguistically competent programs and messages for the proposed target population. One example of a culturally and linguistically competent program is the District's "I Am a Healthy DC Mom" campaign, the first in a series of targeted, culturally competent, collaborative social marketing campaigns designed to develop and enhance understanding of the protective and risk factors critical to producing healthy infants within thriving families. The goal of this program is to increase enrollment of mothers into DOH-sponsored infant mortality prevention programs (specifically African American and Latino mothers) while ensuring that women and babies from preconception to birth and beyond not only survive but thrive. This campaign will be expanded to include fathers, family members, providers and the community at large. Future campaigns will create continuity and include: I Am A Healthy DC Baby, I Am A Healthy DC Father and I Am A Healthy DC Family. The media strategy integrates cultural themes and messages through a process that integrates consumer and community stakeholder recommendations that were developed through a series of listening sessions, focus groups, one-on-one influencer interviews, an environmental scan and guidance from the collective program team (e.g. Perinatal and Infant Health staff, marketing consultants, community partners, etc.). Messages are integrated with creative images which resonate with the targeted communities. Images used launch an identity for a measureable call to action (e.g. early and continuous prenatal care, healthy eating, family harmony, etc.) The branding, "I AM A HEALTHY DC MOM" can easily be expanded to other Title V programs. Evaluation mechanisms include culturally and urban appropriate data analysis in cooperation with business marketing evaluation methods.

An attachment is included in this section.

C. Organizational Structure

HRSA's Maternal Child Health Bureau conducted a site visit in May 2010 to discuss the organizational structure of the Title V Block Grant program overall and the organizational structure of the two bureaus that serve children and youth with special health care needs. CHA provided the following information related to leadership, specific activities and coordination.

LaQuandra Nesbitt, MD, MPH, Senior Deputy Director coordinates the Administration's efforts to help develop an integrated community-based health delivery system, ensure access to preventive and primary health care, and foster citizen and community participation towards improving the health outcomes of women, infants, children, (including children and youth with special health care needs), and other family members in the District of Columbia. Its mission also includes the management of all administrative support functions required by the Administration. As a Board certified family medicine physician, Dr. Nesbitt provides overall technical and policy guidance on the development and implementation of Title V funded programs; works with the Title V director in making funding decisions which support Title V program goals; and identifies and obtains support

from other administrations within DOH and the District government that can leverage Title V resources to expand program offerings and impact.

Anjali Talwalkar, MD, MPH serves as the Deputy Director for Policy and Programs. She develops policy and programs that support the Administration's efforts to develop an integrated community-based health delivery system that ensures access to preventive and primary health care. Consequently, Dr. Talwalkar administers the Title V Maternal and Child Health Services Block Grant and provides oversight and direction to all programs within the administration that are designed to improve the health status of women, particularly those of reproductive age, and infants and children, including those with special health care needs. She provides direct oversight of the operations of the Perinatal and Infant Health Bureau and the Child, Adolescent and School Health Bureau, areas within the administration most focused on maternal and child health needs. She also supervises the staff of the Nutrition and Physical Fitness Bureau, where linkages with WIC, Breast Feeding Consultation and Supplemental Nutrition Education are established to service the maternal/child population.

Karen Watts, RN, is Bureau Chief for the Perinatal and Infant Health Bureau. This Bureau's mission is to improve health outcomes for high-risk pregnant and parenting women and to promote the health and development of their infants into early childhood, as well as the health outcomes for children with special healthcare needs, by facilitating access to coordinated primary and specialty health care and other support services in partnership with their families and community organizations. Its overarching goal is to reduce infant mortality and perinatal health disparities in the District of Columbia primarily through a home visiting approach.

Anjali Talwalkar, MD, MPH serves as the Interim Bureau Chief for the Child, Adolescent and School Health Bureau. Mr. Alvaro Simmons, M.ED, MSW, LSCW recently resigned to accept a position with the federal government. The goal of the Child, Adolescent and School Health Bureau (CASH) is to improve the health and well being of all District pre-school and school-age children and adolescents. Primarily, the group seeks to enhance access to preventive, dental, primary and specialty care services for all preschool and school-age children, including those with special health care needs. CASH also works in conjunction with DC Public Schools (DCPS) and the Office of the State Superintendant of Education (OSSE) to integrate special needs children into the mainstream school population. In addition, this Bureau seeks to improve age-appropriate immunizations among District residents and increase health education and outreach to District residents. This Bureau also implements a citywide asthma plan that includes data collection, public education, self-management support and clinical systems improvement to improve asthma control for District children.

Dr. Pierre Vigilance is Director of the District of Columbia Department of Health and has served in this capacity since April 2008. As the public health agency for the Nation's Capitol, the department serves the District's population of almost 600,000 as well as those who work and spend recreational time in Washington, DC. The department has an annual budget of $268 million and more than 800 staff. In recent years the agency has promoted health and wellness through improved physical activity and nutrition projects such as community-level "Ward Walks" and the Healthy Corner Store Initiative. Under his tenure, the agency has made extensive use of data to drive the agency's activities. He has focused attention on improving data collection and analysis which has led to the publication of the District's HIV/AIDS epidemiology reports, the first city-level Preventable Causes of Death Report, the Obesity Report and the Obesity Action Plan.

Dr. Vigilance received his MD and Master of Public Health degrees from Johns Hopkins University and is residency-trained in Emergency Medicine.

Dr. Vigilance has been reelected to the Board of Directors of the National Association of County and City Health Officials (NACCHO) and will formally assume those duties in July at the Association's annual meeting in Memphis, Tennessee. As part of NACCHO's board, Dr. Vigilance provides public health leadership to address the District's health needs and offers

health policy leadership on the national level. The National Association of County and City Health Officials (NACCHO) represents the nation's 2,800 local governmental health departments. These city, county, metropolitan, district, and tribal departments work each day to protect and promote health and well-being for all people in their communities.

An attachment is included in this section.

D. Other MCH Capacity

The Full Time Equivalent (FTEs) positions supported by Title V funds for 2011 include: Administration (the Office of the Senior Deputy Director includes Grants Management and Program Evaluation, Finance and Data Analysis) -- 38.75; Perinatal and Infant Health Bureau - 10.75; CASH Bureau - 12. Additional staff are in Program Support Services. The total number of FTEs is 61.5. More than 18 parents consistently participate in DOH/CHA-led committees and advisory boards. Parents also participate on sub grantee advisory boards and committees, such as the National Alliance to Advance Adolescent Health, and parents strongly engage in focus groups and Town Hall meetings. CHA is currently seeking candidates for the CASH Bureau Chief position recently vacated by Alvaro Simmons. Other vacant positions to be filled include a nutritionist, lactation coordinator and epidemiologist.

The additional administrative resources available to the Title V Program include the Office of the Deputy Director for Operations, headed by Sandra Robinson, which provides administrative support to all CHA programs and activities, including but not limited to: Budget and financial management; grant monitoring and program evaluation; personnel; performance management, labor relations; procurement; facilities management; risk management; and fleet coordination. While she directly supervises the staff of the Office of Program Support and the Office of Grant Monitoring and Program Evaluation, for the purposes of Title V, a dotted line relationship exists between the managers of these offices and Dr. Talwalkar, in her capacity as Title V Director.

Program Support Office - This office coordinates the following activities for the Title V program: budget preparation and submission, forecast and spending plan development and monitoring, budget variance analysis, budget change requests, and the general oversight of budgetary information and reports to ensure appropriate allocation and earmark requirements are met for Title V resources. The unit also provides accounting operations services including cash management, fund certification, revenue and expenditures tracking and reporting, intra-district transactions, accounts payable certifications and all monthly, quarterly and annual closing activities and annual financial reporting.

Office of Grants Monitoring and Program Evaluation - Charles Nichols, MPP, Chief
This office provides fiscal and administrative monitoring of District and federally appropriated funds in the form of grants and sub-grants to local non-profit and not-for-profit providers. Fiscal monitoring includes ensuring that grant funds are expended in accordance with Federal and local grant regulations; conducting site visits; providing technical assistance to grantees and sub-grantees; and providing ongoing analysis of grant spending to program counterparts. It also provides support for the Administration by designing data collection systems and providing strategic program planning, program evaluation and consultation services. This includes the provision of reliable data on women, children (including those with special health care needs) and families for use in program planning and development.

Finance - DC DOH finance staff has extensive experience in public financing and complies with accounting and fiscal management standards of GAAP and OMB Circular A-133. To meet all grant financing and OMB tracking and reporting requirements, the DC's Office of the City Administrator (OCA) and Office of the Chief Financial Officer (OCFO) have distributed guidance to District agencies on how to separately track and identify all federal funds made to the District. The guidance states that agencies will be held accountable for ensuring full compliance with all Recovery Act requirements. The Office of Budget and Planning (OBP) under the OCFO has

modified the District's accounting system of accounting and reporting (SOAR), as well as the District's Grants Management System (GRAMS). Each department within District Government is responsible for tracking and reporting all federal funds in collaboration with the Office of the City Administrator. All new grants to a city agency is reported to this office by sharing the Notice of Grant Award (NOGA), once reported tracking and reporting requirements are established to ensure compliance with OMB guidance for tracking and reporting of federal funds. The District's guidance calls for the assignment of a unique four digit code (the fund detail) in SOAR for Recovery Act funds, which will facilitate separate tracking. Individual fund details are labeled from specific sources. These fund details help to ensure accurate counts of all line item expenditures. The overall operating budget for the Health Department for fiscal year 2011 is $279,717,936. The operating budget for CHA is $36,381,345.

Several additional resources exist in the District to promote and enhance maternal and child health. These are funded by other sources that support the goals and objectives of the Title V MCH grant. They include: HRSA funded Oral Health Programs; local funding for the Healthy Babies home visitation project; DDOE funding of case management services for children at-risk for lead poisoning as well as environmental assessments of residences; USDA programs such as WIC and SNAP-ED; Early Intervention and special education services provided by the Office of the State Superintendent of Education, DC Public Schools and the Department of Mental Health; teen pregnancy prevention programs funded by the Department of Human Services; and three new school-based health centers plus two wellness promotion programs funded through the Master Tobacco Settlement funds.

An attachment is included in this section.

E. State Agency Coordination

CHA continues its 2010 efforts for intra and interagency collaboration including agency representatives, parents, caregivers, youth and advocates. Sister Administrations in DOH such as HIV, AIDS, Hepatitis, Sexually Transmitted Disease, and Tuberculosis Administration (HAHSTA) and Addiction Prevention and Recovery Administration (APRA), coordinate activities with DC Public Schools, Office of the State Superintendent of Education, Department of Mental Health, Department of Human Services, District Department of Environment, Department of Corrections, Department of Employment Services and Department of Health Care Finance to ensure screening and identification of at-risk families for acute and chronic health/medical, educational, and environmental factors. Collaborative programs are around the following issues: prenatal care and home visitation, Sickle Cell, HIV/AIDs and sexually transmitted diseases, hearing and metabolic screenings and counseling; tobacco cessation, mental health and substance abuse treatment, lead testing and environmental assessment; and nutrition and physical fitness. Programs conduct outreach to residents in homes, shelters, correction facilities, clinics and hospitals. CHA also collaborates with DC City Council to develop and promote policies to ensure access to care, such as allowing students access to asthma treatment in school and supporting the DC Medical Homes project through the DC Primary Care Association.

The other agencies and organizations that collaborate with CHA in supporting and/or providing services to meet the Title V objectives include the sub grantees: Children's National Medical Center, Georgetown University Hospital; George Washington Medical Center, Washington Hospital Center; Howard University Medical Center; Advocates for Justice; National Alliance to Advance Adolescent Health; United Health Care/Breathe-DC; Mary's Center; HSCSN Inc, Fitness for Health, and Associates for Renewal in Education Inc.

Maternal and child health programs, such as Healthy Start and WIC, coordinate with the Office of the State Superintendent of Education (OSSE) efforts around early childhood nutrition and the Adult and Child Food Program. OSSE also requires that Early Care and Education Centers meet standards around healthy foods at meals and snacks. A CHA-funded program provides training to early childcare providers on the requirements and technical assistance around implementation

of the standards.

There are six collaboratives, including Healthy Families, National Alliance to Advance Adolescent Health, Thriving Communities, that provide parenting education and workshops, with the goal being strengthening families, in order that the family unit remains intact but functions in a more healthful manner. DOH Health Educators provide health education workshops to the collaborative on reproductive and perinatal education topics including prenatal care, nutrition, FASD, SIDS, and healthy weight.

Agency coordination efforts also include the efforts of advisory boards and focus groups. The Children with Special Healthcare Needs Advisory Board (CSHCN Advisory Board) serves a key role in identifying and addressing the needs of children with special needs. The CSHCN Board invites parents of special needs children to become involved in their organization to learn more about programs and resources available to them and their children and how to navigate the access points. Recently, the CSHCN Board conducted a training program for families and parents related to Title V.

An Interagency Committee on Children and Youth with Special Health Care Needs was established this grant year and is comprised of representatives within the DC government that serve children with special needs, including CHA Bureaus, Child and Family Services, Department of Mental Health, District Department of the Environment, DC Public Schools, and Department of Health Care Financing. The initial discussions of the Committee included identification of agencies involved with children with special needs, how children are identified, and the need for an environmental scan. The tasks for the upcoming year include creation of a charter, defining its purpose, membership, objectives, activities, etc. Committee will meet quarterly.

the Advisory Committee for Perinatal, Infant and Interconceptional Health and Development, chartered in 2008, focuses on PIHB strategies to decrease infant mortality and product healthy DC moms and babies. In the new grant year the Advisory Board will re-evaluate its charter and review the infant mortality action plan to identify new strategies and initiatives. The Advisory Board identifies and compiles best practices and provides recommendations to CHA based on existing data regarding infant mortality and perinatal outcome disparities. Its evaluation process includes, incorporating systemic assessment of psycho-social and behavioral risk and protective factors as part of perinatal, infant and prenatal interconceptual practice.

The Title V related focus groups provide an opportunity for the community of residents, providers and advocates to respond to specific issues related to policy, access to care, Title V resources are used to sponsor two parent advocates to participate in each AMCHP Conference and one parent to serve as an AMCHP delegate. Parent participants are referred by the Advisory Board and selected by the Title V Director.

Each Title V Director actively participates in board meetings, board development and training. In FY 2009 DOH applied to HRSA, on behalf of the Board, to obtain technical assistance to conduct an organizational assessment. (A copy of that assessment can be made available upon request).

Additionally, the CHSCN Advisory Board has been instrumental in assisting CHA in identifying parents to participate in stakeholders meetings, focus groups and other activities where the input of parents and/or caregivers and guardians can be obtained on MCH issues and concerns, such as access to care, resources, health insurance, and/or education.

DOH's Asthma Program has partnered with asthma programs in Maryland and Virginia to form a National Capital Region Asthma Partnership to address the burden of asthma across state lines. The first Regional Conference was held in May 2010. Data analysts from across the region have collaborated to analyze regional-level asthma morbidity data. Findings will be used to inform

future programs.

An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

During the 2010 grant year DOH continued to focus on infant mortality; children with special health care needs; oral health; lead, asthma, youth injury/violence; data collection, analysis and integration. The Program staff actively participated in inter-agency and intra-agency advisory boards and committees as well as community based coalitions focused on enhancement of maternal/child health issues. CHA awarded subgrants to community based organizations to address and enhance maternal and child health care issues, such as Sickle Cell education and counseling programs, teen prevention strategies and out reach, family navigator and parent information network programs.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	34.4	45.3	48.0	48.0	48.0
Numerator	121	161	217	217	217
Denominator	35175	35513	45182	45182	45182
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

2007 Hospital Discharge Data is currently used until the 2008 and 2009 datasets become available, then this measure will be updated

Notes - 2008

2007 Hospital Discharge Data is currently used until the 2008 and 2009 datasets become available, then this measure will be updated

Notes - 2007

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of
Age increased from a rate of 45.3 per 100,000 to a rate of 48 per 100,000 an increase of 5.9 percent.

Numerator: 2007 DC Hospital Discharge Data
Denominator: DC State Center for Health Statistics 2007 Birth file
United States Census 2007 American Community Estimates (data sets were combined to get the 2007 population for children aged 0-4 years)
.http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-ds_name=ACS_2007_1YR_G00_&-mt_name=ACS_2007_1YR_G2000_B01001&-CONTEXT=dt&-tree_id=307&-geo_id=04000US11&-search_results=01000US&-format=&-_lang=en

Narrative:
/2011/ Asthma continues as a major health consideration for the District's children. Children's National Medical Center funded the 2009 Rand Corporation (Rand) Technical Report "Health and Health Care Among District of Columbia Youth" that assessed the health and health care among more than 100,000 youth residing in Washington, DC (the District). The purpose of the report was to provide a factual basis for advocacy and policy decisions related to children's health in the District and to guide Children's' National Medical Center in the allocation of community benefit resources.

One of the priority health conditions reported by Rand is asthma due to its prevalence, impact on quality of life, and patterns of health care utilization. Among children with Medicaid/Alliance and fee for service Medicaid health insurance coverage, 8 percent and 5 percent of enrollees who use services, respectively, have asthma. Asthma is one primary condition that qualifies a child as a child with special health care needs. Children with asthma use substantial hospital based services. In 2007 it was estimated that 11-16 percent of hospitalizations of children 0-13 were due to asthma.

The Rand report data was further supported by the District's Behavioral Risk Factor Surveillance System (BRFSS) "Data Fact Sheet: Childhood Asthma". The BRFSS presents statistics for lifetime and current asthma rates. Lifetime asthma rates in 2007 were calculated at 19% of the District's children under 18 years of age. There was a 27% increase in asthma from 2005. The 2007 current rate of asthma was estimated to be 15% among children under 18 years of age. This was an increase of about 27% from 2005 to 2007. The data indicate that boys have a higher rate of asthma than girls, and children 5 to 9 years of age had the highest prevalence of lifetime and current asthma.

CHA identified decreasing asthma-related morbidity as a state priority. Some of the activities CHA has implemented to address this health condition include: CHA awarded a sub grant to Children's National Medical Center (Children's) to support parent navigation and peer support for children with special health care needs. One of Children's grant activities included the development of an electronic standardized asthma assessment form that clinicians will use during office visits for children diagnosed with asthma. The electronic note was developed under the grant by providers at Children's National Medical Center and is currently piloted in eight of the hospital's clinics. In the coming year CHA will work with Children's to determine the success of the tool, as well as how to share and offer the application to District providers.
In addition to funding from the Title V MCH Grant, asthma initiatives are also supported through the Primary Care Block Grant and local funding. //2011//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	81.7	72.6	82.4	96.9	97.6
Numerator	4334	4114	4143	5964	5920
Denominator	5303	5668	5026	6155	6065
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final

Notes - 2009
There has been a steady increase in the percent of newborns receiving at least one EPSDT screeing before the age of one.

Source: District of Columbia Medicaid CMS 416 Report.
Numerator: Line 9 <1 year of age
Denominator: Line 8 <1 year of age

Notes - 2008
Data taken from the Medicaid 416 report.

There has been a steady increase in the percent of Medicaid enrolees who received one initial period screen.

Numerator taken from Row 8: Total eligible who should receive at least one initial or periodic screen for children <1.

Denominator taken from Row 9: total eligible receiving at least one initial or periodic screening for children <1.

Notes - 2007
Data taken from national Form 426: Annual EPSDT Participation Report.

Numerator taken from Row 8: Total eligible who should receive at least one initial or periodic screen for children <1.

Denominator taken from Row 9: total eligible receiving at least one initial or periodic screening for children <1.

Barriers to achieve the objective will be addresed in the new partnership between DC Partnership to Improve Health care quality and MAA to create an EPSDT well child registry.

Narrative:
/2011/ DOH continues its efforts to promote well child visits through its Women, Infant and Children (WIC) services; "I Am a Healthy DC Mom" campaign; Healthy Start program; interagency and intra agency collaborations among DOH administrations and Department of Healthcare Finance, Department of Mental Health, Department of Human Services and Child and Family Services Agency. Efforts around an Interagency Agreement (IAA) between the Title V program and Medicaid will yield improvements in surveillance and monitoring as data-sharing will be an element of the IAA. //2011//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
There continues to be no change in separating SCHIP individuals from other Medicaid groups. Medicaid and the District's SCHIP program do not separate the two populations. No data is available.

Notes - 2008
There continues to be no change in separating the report of SCHIP data from EPSDT data. Medicaid and the District SCHIP are part of the same state program, and the Department of Health Care Financing (DHCF) does not publish separate data about SCHIP. Consequently, no data is available.

Notes - 2007
In the past conditions have been less than optimal in acquiring the data, but plans are underway working with our SSDI coordinator to get the information required for future grant applications.

Narrative:
/2011/ The SCHIP and Medicaid EPSDT data are combined because the District does not separately report SCHIP data from the Medicaid data. Therefore, no specific SCHIP EPSDT data is available for the reporting period. //2011/

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	56.4	55.9	71.4	70.6	70.6
Numerator	4449	4727	4923	5017	5017
Denominator	7891	8461	6894	7102	7102
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Currently, the number of birth in 2008 among women aged 15-44 is used to report information for 2009. The 2009 data will be available in 2011, and this measure will be updated.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Birth File.

Source Denominator: District of Columbia State Center for Health Statistics 2008 Birth.

Notes:

Over the last three reporting years the percent of women between the ages 15-44 receiving acceptable prenatal care greater than or equal to the Kotelchuck Index increased by an average of 4% annually.

Notes - 2008
The District of Columbia has a 2-year delay for reporting birth data. Currently, the number of birth in 2008 among women aged 15-44 is used to report information for 2009. The 2009 data will be available in 2011, and this measure will be updated.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Birth File.

Source Denominator: District of Columbia State Center for Health Statistics 2008 Birth.

Notes:

Over the last three reporting years the percent of women between the ages 15-44 receiving acceptable prenatal care greater than or equal to the Kotelchuck Index increased by an average of 4% annually.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Narrative:
/2011/ The District of Columbia has a 2-year delay for reporting birth data. Currently, the number of births in 2008 among women aged 15-44 is used to report information for 2009. The 2009 data will be available in 2011, and this measure will be updated.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Birth File.

Source Denominator: District of Columbia State Center for Health Statistics 2008 Birth File.

Notes:
Over the last three reporting years, the percent of women between the ages 15-44 receiving acceptable prenatal care greater than or equal to the Kotelchuck Index increased by an average of 4% annually.
The births to District residents are less than 9,000 births per year. It is estimated that first time mothers make up about half of the total births per year. Since new mothers represent half the births in DC, the District has an opportunity to not only educate the men and women of the importance of having a reproductive plan but provide accessible resource materials for providers and expectant couples.
The Perinatal Infant Health Bureau (PIHB) continues its oversight of the Healthy Babies project, Family Support Workers and Nurses to provide home visitation to moms and newborns at-risk in Wards 5, 6, 7 and 8. Mary's Center and Washington Hospital Center provide home visitation for Wards 3 and 4. The Healthy Babies Project staff also continues to provide educational services to 14 Department of Human Services Income Maintenance Administration sites.
In May 2009 PIHB launched a comprehensive public information campaign "I am a Healthy DC Mom" with a baby shower. In May 2010 PIHB held another baby shower program at the Washington Hospital Center with more than 150 pregnant women in attendance. The themes included are "I will stay fit and eat right", "I will commit to 40 weeks" and "I will keep my baby safe and healthy". The campaign includes a Public Information component, a Bed Sharing campaign, and distribution of Pregnancy Assistance Kits. Outreach activities include distribution of consumer brochures to grocery stores, pharmacies, Health Services for Children with Special Need, clinics, March of Dimes Maryland National Capital Area, universities, hospitals, mental

health centers, Healthy Babies Project, US Agency for International Development, faith based groups as well as the display of posters on buses and in restaurants and storefronts.
Plans for FY2011 include expansion of the public information campaign to "I am a Healthy DC Baby". The campaign is under development and will follow the same process as "I am a Healthy DC Mom." One component of the campaign will be promotion of breast feeding and healthy work environments with areas for lactating mothers. Consumer brochures and posters will be developed, and a launch event will be planned to kick off this component of the campaign.
//2011//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	58.9	55.8	57.3	53.0	57.6
Numerator	54062	53636	52259	52259	55607
Denominator	91734	96063	91236	98550	96552
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Information taken from Medicaid CMS 416 Report for 2009.

Services fell slightly in 2008, but resumed levels of service seen in 2007.

Numerator: Line 9 Total
Denominator: Line 1 Total

Notes - 2008
Information taken from the Medicaid Form CMS-416: Annual EPSDT Participation Report.

The number of Medicaid eligible children who received a Medicaid paid service has decreased from 72.6% in 2004 to 57.3% in 2007 to 53% in 2008.

Numerator taken from Row 9. Total Eligibles Receiving at least one initial or periodic screen.
Denominator taken from Row 1: Total individuals eligible for EPSDT.

Notes - 2007
Data obtained from the Form 416:Annual EPSDT Participation Report provided by our Medicaid program for FY2007.

Denominator is line 1: total individuals eligible for EPSDT, while the numerator is line 9: Total eligible receiving at least one initial or periodic screen.

Narrative:

/2011/
Information taken from Medicaid CMS 416 Report for 2009.
Services fell slightly in 2008, but resumed levels of service seen in 2007.
Numerator: Line 9 Total
Denominator: Line 1 Total

The data related to services received and paid by the Medicaid program is obtained from the Medicaid Form 416. The number of Medicaid eligible children who received a Medicaid paid service had decreased from 57.3% in 2007 to 53% in 2008. This is still an estimated number because the District does not have a reliable data system to reflect the number of potential Medicaid-eligible children. Some of these children may be covered outside of Medicaid.
The number of Medicaid eligible children who received Medicaid paid services has returned to 2007 levels in 2009 after a slight dip in 2008. Data to accurately reflect the number of potential Medicaid eligible children is currently unavailable in the District. //2011//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	40.3	36.0	42.5	47.3	55.1
Numerator	7103	6523	7119	8533	9127
Denominator	17628	18125	16769	18025	16574
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data taken from the 2009 Medicaid CMS-416 Annual Report.

The percent of EPSDT eligible children receiving any kind of dental services has increased from 36% (2006) to 55.1% (2009), representing a 53.1% increase in services over the 4-year period.

Numerator is taken from row 12A (Age Group 6-9).

Denominator is taken from Row 1 (Ages 6-9): Total individuals eligible for EPSDT.

Notes - 2008
Data taken from the 2008 Medicaid 416 Annual Report.

The percent of EPSDT eligible children increased from 36% in 2006 to 47.3% in 2008.

Numerator is taken from row 12A (Age Group 6-9), while the

Denominator is taken from Row 1 (Ages 6-9): Total individuals eligible for EPSDT (Age group 6-9).

Notes - 2007
Data obtained from the Form 416:Annual EPSDT Participation Report provided by our Medicaid program for FY2007.

Numerator is taken from row 12A (Age Group 6-9), while the denominator is taken from Row 1 Total individuals eligible for EPSDT (Age group 6-9).

Narrative:
/2011/ The Oral Health Program received two HRSA grants: an Oral Health Integrated Systems Grant and a State Oral Health Systems Grant. The grants support funding of the Oral Health Division Chief position and a Program Coordinator. It allows DOH to develop its first statewide oral health plan to improve oral health in the District.

Partnering with Howard University College of Dentistry, Children National Medical Center Dental Pediatric Residency Program and St Elizabeth Hospital Dental General practice Residency program, these entities use the school based dental program as a clinical rotation site for students and dental residents. //2011//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.0	NaN	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	3420	0	4938	4488	4434
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes		
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The District no longer has a clinical program for CSHCN rehab services. However, for 2009 final data for the denominator was obtained for the District of Columbia, from the Kaiser Family State health facts website. .

Notes - 2008
Data used here is from 2007. When 2008 data becomes available this measure will be updated.

The District no longer has a clinical program for CSHCN rehab services. However, for 2007 provisional data was obtained from the District of Columbia's Healthcare Finance Agency. Data is provisional.

The numerator reflects the number of unduplicated SSI beneficiaries who received services. The denominator reflects the number of SSI beneficiaries less than 16 years old in the District. Provisional data supplied by the District's Healthcare Finance Agency

Notes - 2007
The District no longer has a clinical program for CSHCN rehab services. However, for 2007 provisional data was obtained from the District of Columbia's Healthcare Finance Agency. Data is

provisional.

The numerator reflects the number of unduplicated SSI beneficiaries who received services. The denominator reflects the number of SSI beneficiaries less than 16 years old in the District. Provisional data supplied by the District's Healthcare Finance Agency

Narrative:
/2011/ DOH has not provided rehabilitation services to Children with Special Needs for the past three years as a rehabilitation program has never been in existence. However, CHA awarded sub grants to the National Alliance to Advance Adolescent Health to conduct a special transition needs assessment study. The results from analyzing D.C.'s findings from the National Survey of Children with Special Needs were 10 priority needs, including increasing the capacity of pediatric and adult primary care systems to provide transition support for adolescents with special health needs. A sub grant was also awarded to expand Parent Information Network (PIN) capabilities to ensure that the availability of rehabilitation services are communicated to parents and youth. One PIN capability under development is the peer parenting roles, assisting parents to access rehabilitation and other services. Focus groups were convened with parents of children and youth with special health care needs to identify opportunities to improve transition to adult care; self care capabilities; education of parents, providers and advocates.

DOH has developed an interagency agreement with DHCF to facilitate data exchange as well as to continue collaborative activities between agency representatives. //2011//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	matching data files	11.8	8.8	10.6

Notes - 2011
Information taken from a 2008 Birth-Medicaid linked file.
Overall, the percent of low birth weight in 2008 (10.6%) is lower than in 2007 (11.2%).

The Medicaid population LBW rate (11.8%) is lower than 13.3% rate in 2007.

Narrative:
/2011/ DOH continues its efforts to promote well child visits through its Women, Infant and Children (WIC) services; "I Am a Healthy DC Mom" campaign; the Healthy Start program, interagency and intra agency collaborations among DOH administrations and Department of Healthcare Finance, Department of Mental Health, Department of Human Services, and Child and Family Services Agency.

The PIHB will launch "I am a Healthy DC Baby" social marketing campaign. It will continue to conduct home visitation, case management and education programs for pregnant women. Its advisory committee will update the Infant Mortality Action Plan and expand strategies to improve the health of infants born in the District. //2011//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2008	matching data files	17.2	6.6	10.9

Notes - 2011
Data was obtained from the 2008 Infant Death Linked file linked with a Medicaid Recipient file made up of children born in 2008.

Narrative:
/2011/ An initial review of 2008 Infant Mortality shows that the District's Infant Mortality Rate has decreased from 13.1% in 2007 to 10.9% in 2008. Of the 116 infant deaths the two leading causes of infant mortality are complications related to the placenta and cord membrane, and genetic malformations.
Under the First Candle Program, the Perinatal Infant Health Bureau (PIHB) continues to distribute cribs that can be used until the child is five years of age because it converts into a bed when the child outgrows the crib. In addition, the program distributes a pack and play type crib to eligible District residents.
PIHB works with birthing centers and hospital discharge staff to ensure that all children receive Universal Newborn Metabolic Screening for 40 metabolic and genetic disorders before hospital discharge. PIHB staff will then promptly follow up on positive screens.
PIBH staff attended and presented at the Fetal Alcohol Syndrome and Disorders Symposium. The objective of the symposium was to increase the awareness of the risk associated with perinatal alcohol use and its effects on the newborn and ultimately, the community. //2011//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	68.3	82.6	74.7

Notes - 2011
Information taken from a 2008 birth-Medicaid linked file.

Overall, the total (Medicaid and non Medicaid) percent of women who received prenatal care in the first trimester (74.7%) increased by 2.3 percent as compared to 73% in 2007. Source: DC 2008 State Center for Health Statistics 2008 Birth File

This increase is also mirrored when looking at the 2008 Medicaid population 68.3% is higher than the 63.8% in 2007.

Narrative:
/2011/ In May 2010 the Perinatal and Infant Health Bureau conducted a focus group comprised of men
and women in Wards 7 and 8 to discuss access to and perception of seeking care in the first trimester of pregnancy. Initial review of responses indicated that access barriers and financial reasons were not the primary reasons for failure to enter care during the first trimester. Participant responses included: they thought they had the flu or did not know they were pregnant. Findings of the focus group will be analyzed and reported in the fourth quarter of 2010. Health and sexuality education in schools as well as outreach campaigns are focused on educating girls and women on reproductive health. //2011//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files	61.8	80	70.6

Notes - 2011
Information taken from a 2008 birth-Medicaid linked file.

Overall, 70.6% received an adequate Kotelchuck classification in 2008 as compared to 71.4% in 2007.

Medicaid population 61.8% is slightly better than the 60.6% in 2007.

Narrative:
/2010/ PIHB expanded its social marketing campaign "I am a Healthy DC Mom" aimed at pregnant women and their children. WIC, school nurses, and Healthy Start staff focus on pregnant teens and women and facilitate linkages to clinical care and support services. //2011//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	300

Notes - 2011
Source: Medical Assistance Administration, DC Department of Health.

Notes - 2011
Source of Data: DC Department of HealthCare Finance.

Narrative:
/2011/ The eligibility for Medicaid-SCHIP for District children 18 years or younger remains at 300% of the Federal Poverty Level. //2011//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	300

Notes - 2011
Source: Medical Assistance Administration, DC Department of Health.

Notes - 2011
Source of Data: DC Department of HealthCare Finance.

Narrative:
/2011/ The eligibility for Medicaid-SCHIP for District children 18 years or younger remains at 300% of the Federal Poverty Level. //2011//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	300

Notes - 2011
Source: Medical Assistance Administration, DC Department of Health.

Notes - 2011
Source of Data: DC Department of HealthCare Finance.

Narrative:
/2011/ The eligibility for Medicaid-SCHIP for District children 18 years or younger remains at 300% of the Federal Poverty Level. //2011//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey	2	No

for at least 90% of in-State discharges		
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2011

Narrative:
/2011/ The Perinatal and Infant Health Bureau will expand its social marketing campaign to "I am a Healthy DC Baby." The campaign will include public information, nutrition and breast feeding, safe sleeping, growth and development information, immunizations, screening, and well baby visits.
The Nutrition and Physical Fitness Bureau provides and monitors the provision of nutritional services (checks for nutritious foods, nutrition education and breastfeeding support) through the Special Supplemental Nutrition Program for Women, Infants and Children (WIC.) It provides food distribution and health promotion services for pregnant and postpartum DC women and breastfed and non-breastfed infants and children to age 5. It also distributes farmers' market food checks for WIC participants through WIC Farmers' Market Nutrition Programs.
CHA plans to evaluate the implementation of a PRAMS survey in in this grant year. The additional data collected through the PRAMS survey will facilitate development and evaluation of current and future programs. //2011//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	No

Notes - 2011

Narrative:
/2011/ The Urban Institute's Report On the Road to Adulthood - A Databook about Teenagers and Young Adults in the District reported positive news regarding teens who smoke, drink alcohol, and use drugs. District youth rank lower in participating in these habits than youth nationally, especially black District youth. For instance, the share of District 9th--12th graders in 2007 that smoked cigarettes at least once in the month before the survey was only 11 percent, compared with 20 percent nationally. District youth smoking rates have fluctuated over time but have been generally decreasing, similar to national trends. Black youth were less likely to smoke than Hispanic youth. (White youth were not available for analysis in YRBSS because of the small sample size.) In 2007, 9 percent of black high schoolers smoked at least once a day, compared with 15 percent of Hispanic youth.
The report also states that while District 9th--12th graders were less likely to use cigarettes and alcohol than all youth nationally, while the same proportion of District and national 9th--12th graders reported using marijuana and cocaine. In 2007, 21 percent of 9th--12th graders in the District and 20 percent of high schoolers nationally reported marijuana use within the past month (the difference in national and District rates was not statistically significant). Unlike earlier trends, black youth were more likely to use marijuana than Hispanic youth. In 2007, 21 percent of black

youth reported marijuana use, compared with 15 percent of Hispanic youth. This difference has not been consistent over time. Black and Hispanic youth both reported 30 percent marijuana use during the citywide peak in 1997, and black youth reported lower rates of marijuana use than Hispanic youth during the citywide drop in 2005 at 14 and 17 percent, respectively.
CHA is studying the specific needs for a PRAMS survey based on the findings and recommendations from the Needs Assessment. //2011//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Community Health Administration (CHA) continues its oversight and management responsibilities of the Title V Maternal and Child Health Block grant. Its responsibilities include but are not limited to: promoting the goals and objectives of the Title V grant, budget management, development and oversight of sub grants to community based organizations providing programs to support Title V objectives, leading and/or participating in inter- and intraagency
collaborative efforts, periodically reporting the status of activities and accomplishment of objectives, and attending HRSA meetings.

The mission of the Community Health Administration is to improve health outcomes for targeted populations by promoting coordination within the health care system, by enhancing access to prevention, medical care and support services, and by fostering public participation in the design and implementation of programs for District of Columbia women, infants, children (including children with special health care needs) and other family members.

DOH's strategic plans include the adapting a model for better understanding the development of disease and the promotion of health. Neal Halfon, MD, MPH, Director, UCLA Center for Healthier Children, Families, and Communities, and Professor of Pediatrics, Health Sciences and Public Policy designed the Life Course Health Development (LCHD) as a approach to build on longitudinal connections and development periods models by specifying the biological and behavioral mechanisms that determine health trajectories. Dr. Halfon and others have suggested that the health development process is determined not just by the cumulative impact of risk and protective factors but by the timing of exposures. When positive or negative influences occur during vulnerable periods, such as early childhood, their impacts can be stronger and more lasting than when the same exposures occur at other times. Thus, there are optimal times for positive interventions or -- more pointedly -- missed opportunities when these interventions do not occur during the important developmental periods. Likewise, there are periods of heightened vulnerability, during which negative exposures can be especially damaging. DOH supports that the LCHD model provides an opportunity to transform children's health at the "early part of the life span, when long term health planning is most intense and higher levels of developmental plasticity enable interventions to exact greater returns on resources invested. In many cases, promoting optimal lifelong health may be best achieved through means other than "traditional" health care interventions." The objective will be to construct a process to guarantee meaningful health care coverage, routinely utilize teams of visiting maternal child health nurses, establishing readily accessible child care and child development centers, and providing other income and family support for families with young children. The LCHD model will guide CHA in evaluating current programs, identify gaps in services and prioritize life-long prevention interventions. This process will require review of current and availability of meaningful health insurance coverage for all children plus significant investments in community-based prevention, health promotion, developmental support services, and information systems to provide the health development scaffolding that children need to thrive. CHA proposed adoption of this strategy would help to reverse the alarming trend of health disparities for the youngest generation and focus on early, high-return investment on children's health and subsequently, their future. Each of CHA's Bureaus leadership guide staff and grantees in meeting the objectives of the Bureau as related to the Title V grant.

Nutrition and Physical Fitness purpose is to provide food, health and nutrition assessments and interventions, education and referral services to District families, infants, children, and seniors to affect dietary habits, foster physical activity, decrease overweight and obesity rates and thus improve health outcomes of District residents.

The Perinatal and Infant Health Bureau mission is to reduce perinatal outcome disparities

(including infant mortality, very low birth weight, and preterm births and to improve the preconception/interconception health of women and infants residing in the District of Columbia. Its activities include: the Consortium; DC Healthy Start Project; DC Linkage and Tracking System, Epilepsy Awareness Project, Fetal Alcohol Awareness Syndrome Prevention Program. The following programs are implemented through PIHB:
Cancer and Chronic Disease Prevention Bureau mission is to reduce the incidences, morbidly and mortality of cancer and chronic disease in the District.
Primary Care Bureau mission is to increase access to quality primary health care services within an integrated health care delivery system. The Primary Care Bureau oversees the development of three new school based health care clinics.

Pharmaceutical Procurement and Distribution Bureau was organized in FY2010 under CHA. This Bureau maintains a timely and efficient drug delivery rate of greater than 99%, and assures that the Department of Health continues to maintain access to drug discount programs that will allow as many District residents as possible, access to life saving medications.
In the upcoming grant year activities CHA will focus on and consider the American of Maternal and Child Health Program (AMCHP) federal opportunities presented in "The Patient Protection and Affordable Care Act Maternal and Child Health Related Highlights". These Federal funding opportunities include: Prevention and Public Health; Childhood Obesity Demonstration Project; Community Transformation Grants, Maternal, lnfant, and Early Childhood Home Visiting Programs; Personal Responsibility Education, Restoration of Funding for Abstinence Education and Support, Education and Research for Postpartum Depression.

CHA will also work with the school based program to ensure that they conduct youth surveys related to the DC YRBSS. The response rates were not weighted because the overall response was below 60%. As a result YRBSS was not used.

The detailed description of programs provided by each Bureau is attached in section Agency Capacity.
An attachment is included in this section.

B. State Priorities

The State MCH Priorities for the FY2011 are consistent with the recommendations presented in the Title V Maternal and Child Health Needs Assessment and the National Alliance to Advance Adolescent Health ‘s special transition needs assessment study, analyzing the District's findings from the National Survey of Children with Special Needs. CHA determined the rankings of the state priorities
based on: the Title V reporting requirements, a review of vital statistics, health disparities reports; analysis of services; Federal laws, and input from community agencies, forums, focus groups and the public.

The District's priorities for the next 5 years include:
1. Decrease infant mortality. (ES) An existing outcome measure which must be continued as a priority.
/2010/ The PIHB will continue its oversight of the ongoing Healthy Start and Family Support Workers programs that provides home visitation and case management services to women and their babies in Wards 5, 6, 7 and 8 and Mary's Center and Washington Hospital Center in Ward 5. The Bureau also collaborates with the Nutrition and Physical Fitness Bureau and the DDOE to identify residents receiving WIC benefits at-risk, including lead exposure and other environmental issues. Referral sources are children at risk with elevated lead blood levels; newborns with abnormal hearing screens; and/or newborns with positive metabolic screening levels.
PIHB social marketing campaign will expand to include "I am a healthy DC baby" and outreach to pregnant women and new mothers to instruct them on the care and health needs of a newborn, including but not limited to: screening, testing, periodic primary care visits, breast feeding and nutrition, growth and development, resources, etc.

Continue to collaborate with the DC Public Schools to continue health and sexuality education programs. Provide assistance with referrals and case management for pregnant teens.
Other activities include: submission of grant applications to expand home visitation to children at risk ages 0-8 years of age; in collaboration with the Advisory Board review the Child Action Plan and identify new strategies for implementation; continue follow-up of newborns with positive metabolic screening; collaborate with the managed care organizations to develop a global assessment, a quality improvement initiative.

2. Enhance nutrition and increase physical activity for children and youth through increased access to healthy foods and physical activity opportunities and through breastfeeding promotion. (ES) This was identified in the needs assessment as a priority.
/2011/ The Nutrition and Physical Fitness Bureau increased its Farmers Markets recruited 18 new farmers, certified 5 new markets, signed up 7 new farm stands and farmers on Wheels, and authorized 45 farmers to redeem WIC Cash Value Checks (CVC) for produce.
It is launching a major bus and rail campaign to advertise the new WIC food packages for two months. There are three ads, and it is currently developing a multi media campaign that will include informational videos to answer frequently asked questions relative to eligibility, certification and authorized foods for participants, authorized vendors and cashiers. The Bureau is also procuring a new WIC Mobile Unit to deploy to underserved areas of the city.
It is collaborating with the PIHB to support breasting feeding and expand breastfeeding promotion and education prior to delivery, emphasizing the resources NPFB provides, which includes Breastfeeding Peer Counselors (BPC), Lactation Consultants, availability of breastfeeding pumps and working with hospital maternity wards ("Baby-Friendly Hospitals"). Promote employer supported reasonable breast feeding areas in compliance with amendment to the Fair Labor Standards Act.
Identify and establish community partners, develop nutrition education flyers/banners for community organizations servicing District residents eligible for SNAP--ED benefits. Collaborate with sub-grantees to provide nutrition education activities for District residents eligible for SNAPED
benefits.
USDA has assigned a caseload of 6,647 for FY 2010; however the grantee has not attained participation beyond 95% of the assigned caseload which has resulted in federal grant reduction by $54,000. As a result the program is proposing that the future grant be modified to tie the grant funding more directly to performance.
Starting 3rd quarter of FY 2010, develop and implement additional physical activity lessons and hold group sessions in clinics that promote physical activity. Include physical activity component with all SNAP-ED nutrition education lesson plans.
NPF Bureau will collaborate with Medicaid to provide guidance and relevant information to health care providers regarding prevention and obesity related services that are available to Medicaid enrollees, including obesity screening, counseling for children and adults.
The District's Healthy School Act 2010 was enacted to establish local nutritional standards for school meals, to establish healthy vending, fundraising, and prize requirements in public schools, 35 to require public schools to participate in Federal meal programs to the greatest extent possible,
to solicit feedback about healthy meals, to require disclosures of ingredients and allergens in school meals, and to provide at least 30 minutes to eat lunch; to establish a farm-to-school program, to create a preference and a monetary incentive to serve foods that are locally-grown, locally processed, and minimally-processed from growers engaged in sustainable practices, to require teaching about the economic, environmental, and nutritional benefits of fresh, local foods, to prohibit public schools from entering into contracts that prevent the purchase of local foods, to require the disclosure of the origin of foods served in public schools, to provide for grants to create a local farm-to-school distribution system, to establish a local flavor week and a harvest of the month programs, and to require an annual report and recommendations on farm-to-school initiatives; to establish minimum levels of physical education and activity for students, to provide for exemptions for students with disabilities, students with chronic health problems, or schools

that lack the facilities, to prohibit physical education to be used as punishment, and to require an annual report about the compliance with these requirements //2011//

3. Reduce teen pregnancy. (PBS, DS) Identified as a priority in the Needs Assessment and also an existing performance measure which must be continued as a priority.
/2011/ The 2009 Urban Institute's "Road to Adulthood -- a Databook about Teenagers and Young Adults in the District reports that high school students in the District were more likely to be sexually active and to have been with multiple partners than teenagers nationally. In 2007, 58 percent of 9th--12th graders in the District had ever had sexual intercourse, compared with just 48 percent nationally, and 22 percent of District high schoolers had had sexual intercourse with four or more partners, compared with 15 percent nationally. In fact, 41 percent of District high schoolers had had sex with at least one partner during the month before the YRBSS survey, compared with just 35 percent nationally. The good news is that District youth were more likely than youth nationwide to use condoms during sexual intercourse and were less likely to use drugs or alcohol. For instance, 71 percent of District high schoolers in 2007 used a condom during sex compared with 62 percent nationally, and 17 percent used drugs or alcohol during their last sexual intercourse compared with 23 percent of youth nationally. The share of District higher schoolers who were sexually
The school nurse program will continue health and sexuality education to DC Public Schools students. CHA will evaluate the "Girl Talk" and "Healthy Generations" sub grantee program and determine their success in mitigating teen pregnancy and improving parenting skills of teen mothers. CHA will continue to present Health and Sexuality Education Programs at various DCPS and a few Charter Schools as well as the Woodson Adolescent Wellness Center that will continue to provide health and sexuality education, comprehensive health services, and pregnancy prevention programs. The three new high school based clinics will also provide these education programs and services.
CHA will periodically collect and analyze data related to maternal and child health, including but not limited to metabolic screening, newborn hearing, case management of pregnant teens, infant mortality.
CHA will develop a Youth Action Plan that includes prevention or increasing teen pregnancies and monitoring and surveillance of maternal child services. //2011//

4.Increase access to medical homes for CSHCN and support coordinated, family-centered systems of care. (IBS, DS) This was identified in the CSHCN transition needs assessment as a priority.
/2011/ CHA will continue to collaborate with the DC Primary Care Association, National Alliance to Advance Adolescent Health and the DC Public Schools to implement medical homes and support access to system of care through policies and sub grants that support seamless and coordinated systems of care for District residents, including children with special health care needs. One focus will be developing a strategy for a single point of connection for information about how to access services and supports for CYSHCN.
CHA will coordinate the transfer of the web site developed by Children's National Medical Center under its sub grant for Parent Navigation Network tasks. The web site was design to assist with the seamless and coordinated system of care by providing information on transition resources and transition research to teens, parents and caregivers, and heath care providers.
CHA will also collaborate with National Alliance, HCFA, the American Academy of Pediatrics, medical centers and safety net providers (e.g. community health centers) to create a medical home initiative for CSHCNs.
Identify opportunities to implement an enhanced reimbursement model for practices meeting at least level one of the Physician Practice Connections Patient Centered Medical Home recognition program. //2011//

5. Reduce morbidity due to asthma among children and youth. (ES)
An existing State measure which must be continued as a priority.
/2011/ CHA will continue the community collaborative efforts with United Medical Center --

Breathe-DC and DHCF Chronic Care Collaborative Astma Initiative to promote asthma education and tobacco cessation activities.
CHA will continue to collaborate with Children's National Medical Center to promote the electronic standardized asthma assessment tool, including adaptation of the tool as an open source application; and distribution to other DC providers.
CHA will continue to collect asthma related data through disparate data sources to facilitate the development of strategies to mitigate asthma related morbidities.
CHA will continue to collaborate with DDOE to identify children at risk for lead and dust exposure that may trigger asthma symptoms.
CHA will continue to collaborate with IMPACT DC that provides asthma education in schools and community outreach directly to students.
CHA will continue to collaborate with school nurse program to identify children with asthma and develop a care plan that permits children to self medicate for asthma during the school day.
CHA will develop an information technology strategy to transfer and make available the electronic asthma assessment note to other providers. //2011//

6. Reduce violence and injury among children and youth. (PBS, DS)
This was identified in the needs assessment as a priority.
/2011/ CHA will develop a Youth Action Plan to address issues specific to the youth population. The Action Plan will model the Child Action Plan format and focus will include mood and behavioral health issues, intentional injury and suicide prevention; truancy; chronic illnesses; etc.
CHA will collaborate with MPD, DYRS, DMH, and other agencies, providers and advocate to address the issues related toward and by children and youth.//2011//

7. Improve oral health among children, youth and pregnant women. (PBS,DS)
This was identified in the needs assessment as a priority.
/2011/ The Oral Health Program received two HRSA grants: Oral Health Integrated Systems Grant and a State Oral Health Systems Grant. The grants support funding of the Oral Health Division Chief position and a Program Coordinator. It allows DOH to develop the first statewide oral health plan to improve oral health in the District.
Partnering with Howard University College of Dentistry, Children National Medical Center Dental Pediatric Residency Program and St Elizabeth Hospital Dental General practice Residency program, these entities use the school based dental program as a clinical rotation sites for students and dental residents.
The Oral Health Division is partnering with the DC Board of Dental Licensing to address oral health disparities to allow non-dental providers to administer fluoride varnish to children.
Other activities include: expand community water fluoridation; expand fluoride varnish and dental sealant programs in DC public schools; establish an oral health network to develop local solutions to access problems; improve the ability to conduct epidemiological surveys and data collection, tracking and evaluation of oral health services and programs throughout the Distinct. Consider increasing access to dental services for Children with Special Health Care needs, especially, children that are behavioral and severely handicapped that may not be treated in school or need extensive services done under sedation. //2011//

8. Reduce sexually transmitted infections in adolescents. (PBS, DS)
An existing National measure which must be continued as a priority.
/2011/ CHA will continue to provide HIV/AIDS and sexually transmitted diseases screening and prevention services for adolescents. It will continue to collaborate with DC Public School and Charter Schools --School Nurse program and HIV/AIDS Administration to screen and counsel adolescents. School nurses will continue its health and sexuality education programs. //2011//

9. Increase lead screening for children under six years of age. (PBS)
An existing state measure which must be continued as a priority.
/2011/ Continue to screen children at 12 and 24 months per DC law, AAP and DC periodicity schedule. DDOE will continue its collaborate efforts with PIHB and NPFB to identify women and children at environmental risk ad provide environmental screening for lead and dust; track

children's lead screening and reporting; implement the new CDC Healthy Homes Preventive Poisoning System (HHPPS) to track lead and other environmental exposures; and provide case management to children at risk for lead poisoning and test sources of lead contamination in the home. CHA will collaborate with Medicaid to identify opportunities for increasing lead screening of children enrolled in Medicaid programs, as well as consumer education through programs such as the PIHB social marketing campaign "I am a healthy DC Baby" campaign; provider education; Healthy Start programs; WIC education programs; and the school nurse program. //2011//

10. Improve surveillance and monitoring of maternal and child health. (IBS)
Identified in CAST V as a priority.
/2011/ Under the Patient Protection and Healthcare Act, CHA will identify Federal grant opportunities to support data collection and integration.
CHA plans to hire an epidemiologist to assist with analysis of Title V data from disparate sources, as well as provide guidance to program staff to counsel sub grantees in the required collection and reporting of data as a component of outcomes analysis. //2011//

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	98	90
Annual Indicator	NaN	100.0	100.0	86.0	100.0
Numerator	0	30	30	43	41
Denominator	0	30	30	50	41
Data Source				Newborn Screening Program	Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95	95	96	96	98

Notes - 2009
Program identified 41 newborns with confirmed presumptive positives. All of them entered treatment.. The breakdown is as follows:

Acylcarnitine 1
Amino Acid 1
CAH 17-OHP 0
Cystic Fibrosis 1

Biotinidase Deficiency 1
Congenital Hypothyroidism 6
Hemoglobinopathies 31
Galactosemia 0
TOTAL 41

Notes - 2008
Realignment in CHA, as well as loss of some key personnel, left the program with less documentation than in previous years. The previous administration did not have procedures in place for properly storing or archiving data on follow-up of positive screens. There was also no way to reconstruct the missing data after the fact. Therefore precautions need to be in place now. CHA is looking into other data retrieval mechanisms as well as data storage mechanisms. One DOH employee will maintain the quality of the data and the data wil be stored in a central location.

Notes - 2007
2007 data is not available at this time and will be updated.

CHA discovered previously that the wrong information was being entered from Form 6. This is noted and will be corrected in the future.

a. Last Year's Accomplishments
Program identified 41 newborns with confirmed presumptive positives. All of them entered treatment. The breakdown is as follows:

Acylcarnitine 1
Amino Acid 1
CAH 17-OHP 0
Cystic Fibrosis 1
Biotinidase Deficiency 1
Congenital Hypothyroidism 6
Hemoglobinopathies 31
Galactosemia 0
TOTAL 41

1. PIHB continued the Healthy Start Program and Hospital Newborn Discharge Program to ensure that each District newborn receives a follow-up visit within 48 hours of birth and within 1 month.
2. Continued utilization of the family support workers to provide complementary support services that address medical, social, and psychological risk factors affecting pregnant and parenting women and their children.
3. Case managers assisted residents in enrollment in a case management program either through the Medicaid managed care program, WIC, and teen pregnancy programs.
4. Continued follow-up for children with abnormal screens by enhancing case management to ensure that each infant born in a District hospital who receives an abnormal newborn genetic/metabolic screening receives short term follow up from identification to specialty referral. These infants are followed to diagnosis. The PIHB will continue to develop and implement a process for the long-term follow up, allowing care coordinators to provide enhanced follow up beyond disorder identification to ensure comprehensive, coordinated care and treatment for those infants affected. Early identification and appropriate and continuous treatment is vital to addressing the morbidity and mortality of these infants.
5. Continued its collaboration with the Department of Corrections and schools for the early identification of pregnant teens and women and referrals to health care services and other support services.
6. Continued social media campaign.

7. Hosted a follow- up Healthy Start Conference to address progress in communications and strategies to improve outcomes.
8. Participated in Fetal Alcohol Syndrome and Disorders symposium

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perinatal and Interconceptual Health Advisory Group	X			
2. Healthy Start Conference	X	X		
3. Family Support Worker Program	X			
4. Case Management and Home Visitation	X	X		
5. Environmental screening	X	X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
PIHB continues the Healthy Start Program and Hospital Newborn Discharge Program.

Continue utilization of the family support workers to provide complementary support services that address medical, social, and psychological risk factors affecting pregnant and parenting women and their children.

Case managers assist residents in enrollment in a case management program either through the Medicaid managed care program, WIC, and teen pregnancy programs.

Continuing follow-up for children with abnormal screens by enhancing case management to ensure that each infant born in a District hospital who receives an abnormal newborn genetic/metabolic screening receives short term follow from identification to specialty referral. These infants are followed to diagnosis.

Continues its collaboration with Department of Corrections and schools for the early identification of pregnant teens and women and referrals to health care services and other support services.

Conitnue social media campaign.

c. Plan for the Coming Year
1. Continue efforts for early identification of pregnancy and monitor timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC Health Care Alliance through outreach programs at WIC, Department of Corrections, and DC Public Schools in collaboration with school nurses;
2. Increase and monitor well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge through Family Support Worker and Home Visitation Program.
3. Enhance community-based screening and prevention services for at risk families and youth served by Child and Family Services Agency.
4. Facilitate outreach and linkages to care for homeless pregnant women and those living in a shelter.
5. Expand social media campaign to promote healthy babies, healthy women and healthy fathers.
6. Review and update strategies for the Infant Mortality Action Plan as well as the Child Health

Action Plan.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**15752**					
Reporting Year:	**2008**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	15131	96.1	5	0	0	
Congenital Hypothyroidism (Classical)	15131	96.1	14	0	0	
Galactosemia (Classical)	15131	96.1	4	1	1	100.0
Sickle Cell Disease	15131	96.1	827	34	30	88.2
Biotinidase Deficiency	15131	96.1	0	0	0	
Cystic Fibrosis	15131	96.1	1	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	15131	96.1	7	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57	57.5	58	58	58
Annual Indicator	55.5	55.5	53.1	53.1	53.1
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	58	58	59	60	61

Notes - 2009
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

Notes - 2008
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2007
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

a. Last Year's Accomplishments
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

1. The Sickle Cell Program continued to support families in decision-making at each level of their child's care. The "Faces of our Children" Program is a partnership with a local organization focusing on sickle cell disease education to conduct outreach and education activities. It supports teens' understanding of the importance of genetic counseling services.
2. Sub grant awarded to Advocates for Justice to develop and implement the "Parent Information Network" grant that supports families' partner in decision making at all levels.
3. The Child, Adolescent and School Health Bureau's Epilepsy program established a partnership with the District's managed care organizations to ensure children with special healthcare needs such as those suffering from epilepsy and seizure disorders receive coordinated care within a medical home.
4. Sub grant awarded for Youth in Transition with Epilepsy and Seizure Disorders.
5. The MCOs provided care coordination, support group meetings, educational sessions and mailings, service satisfaction surveys, community forums, and support for children and youth to attend camps during the summer.
6. Collaborated with DDOE Lead Program to provide education to families to mitigate dust and lead in homes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Case Management and Home Visitation	X	X		
2. CSHCN Interagency Advisory Board				X

3. Family Support Worker program	X			
4. Continued collaboration with Family Voices and National Alliance	X		X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Monitor and evaluate the Parent Information Network sub grantees.
2. Continue to support the Sickle Cell and Epilepsy and Seizure Disorder programs.
3. Continue to collaborate with hospitals and birthing centers to facilitate the replacement of current hearing screening equipment in hospitals and birthing centers with equipment that does not require an audiologist to interpret screening results.
4. Conducted two focus groups in March and April 2010, with 31 adolescents and young adults, ages 13 to 23, and 19 parents. The topic areas addressed included reliance on pediatric health providers as their usual source of care, teens' knowledge about their health conditions, perspectives and experiences on transition to adult care, and recommendations for transition support.

c. Plan for the Coming Year

1. Issue a request for a proposal and select a sub grantee to continue the activities of Parent Information Network program.
2. Continue to explore strategies with OSSE to improve follow-up with children with positive hearing screen results. Continue to distribute information to hospitals for parents whose child does not pass their initial hearing screening.
3. Include hearing screening information in the "I am a Healthy DC Baby" social campaign.
4. Issue a request for a proposal and select a sub grantee to improve services for children with mood, behavioral or developmental disorders.
5. CHA will engage with Department of Healthcare Finance to look at funding streams for privately insured patients whose coverage does not adequately cover needed goods or services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	43	43.5	44	44	40
Annual Indicator	41.4	41.4	36.9	36.9	36.9
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	41	42	43	44

Notes - 2009
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

Notes - 2008
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2007
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

a. Last Year's Accomplishments
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

1 Awarded a sub grant to provide transition case management services for children with special health care needs to facilitate their transition from pediatric to adult care. The scope of work includes: convening focus groups with children and youth with special health care needs and parents, and having a parent navigator working with families and children through a community based organization.
2 Parent Information Network continues to expand from the pilot phase to implementation phase. The scope of work includes expansion of navigation services to families with children with special needs; and development of a 'help desk' or resource directory of state and regional services for children with special health care needs, etc.
3 Awarded a sub grant to assist Youth in Transition with Epilepsy and Seizure Disorders. Scope of tasks included: conduct focus groups, provide education through schools and community events; and provide navigation services and referrals.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. PIHB case management and home visitation services	X	X		
2. SHCN managed care organization case management services	X			X
3. Family Support Worker program	X			
4. CHA collaboration with Family Voices	X	X		
5. Subgrant to National Alliance for Adolescent Health - Transition services for CSHCN	X	X		

6. Interagency and intraagency collaboration			X	
7. DDOE Lead screening and case management for at risk children	X		X	
8.				
9.				
10.				

b. Current Activities

1 Monitor and evaluate sub grant award for the Parent Information Network

2 Monitor National Alliance to Advance Adolescent Health sub grant focused on core transition outcome to achieve continuity within the medical home model of care between the pediatric and adult health care systems.

3 Monitor Youth in Transition with Epilepsy and Seizure Disorders

4 Collaboratw with Department of Healthcare Finance (DHCF) to ensure health coverage and services for children and families with SHCN as they transition through life stages.

5 Collaborate with DC Primary Care Association (DCPCA) to ensure families with SHCN are included in strategies for medical homes, including ensuring a sufficient number of qualified providers.

c. Plan for the Coming Year

1 Monitor and evaluate grant award for the Parent Information Network and other sub grants

2 Continue collaboration with DHCF to ensure health coverage and services for children and families with SHCN as they transition through life stages

3 Continue collaboration with DCPCA to ensure families with SHCN are included in strategies for medical homes, including ensuring a sufficient number of qualified providers.

4 Evaluate outcomes of the National Alliance to Advance Adolescent Health sub grant.

5 Continue collaboration across agencies and organizations to identify at risk children and link to case management services.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61.5	62	62.5	62.5	63
Annual Indicator	55.9	55.9	62.7	62.7	62.7
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	63	63	64	64	65

Notes - 2009
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

Notes - 2008
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2007
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

a. Last Year's Accomplishments
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

1 The Perinatal and Infant Health Bureau continued the Healthy Start Program and MOM van outreach efforts to enroll pregnant and parenting women in service programs.
2 Collaborated with Department of Corrections and DC shelters to provide services to pregnant women and coordinated access to services and benefits.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with DC DHCF Medicaid Program	X			
2. Collaboration with DC DHCF Alliance Program	X			
3. Convene a workgroup comprised of DC agencies from across all departments who are involved with serving and supporting children and youth with special health care needs and their families as well as families and youth, healthcare delivery organization		X	X	X
4. Develop strategies to implement Kathy Beckett waiver.	X		X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1 Continue Healthy Start case management program that facilitates access to services and benefits

2 Continue monitoring referrals for children with positive hearing screens for follow-up services
3 Continue collaboration with DDOE Lead Program to facilitate access to residences to assess for dust and lead exposure.

c. Plan for the Coming Year
1 Continue the Healthy Start Program and MOM unit outreach efforts to enroll pregnant and parenting women in entitlement programs.
2 Continue the collaboration with Department of Corrections and DC shelters to provide services to pregnant women and coordinate access to services and benefits.
3 Continue the collaboration with DDOE Lead Program to identify residences where children are at risk.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	72	72.5	73	73	90
Annual Indicator	69.9	69.9	88.8	88.8	88.8
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	92	92

Notes - 2009
The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

Notes - 2008
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2007
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to

generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

a. Last Year's Accomplishments

The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated. It appears that there is a significant improvement on families' ability to access community based services

1 Continued collaboration with the MCOs and Department of Healthcare Finance.
2 Expanded the Parent Information Network Program to include training parent peer counselors to facilitate navigation services to more than 100 families of special needs children.
3 Awarded a sub grant for Youth in Transition with Epilepsy and Seizure Disorders.
4 Convened Children with Special Health Care Needs Advisory Board comprised of parents, advocates and providers; developed strategic plan as well as held a mini retreat related to the Title V MCH grant.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PIHB Case Management program	X			
2. PIHB Family Support Worker program	X			
3. CSHCN Advisory Board	X			
4. CHA continued collaboration with Family Voices	X			
5. CHA continued collaboration with National Alliance	X			
6. CNMC sub grant for family navigation services	X			X
7. Development and adoption of a universal application for services and support programs that impact CSHCN.			X	
8.				
9.				
10.				

b. Current Activities

1 Collaborating with MCOs
2 Collaborating with Department of Health Care Finance to support increased efforts for well child visits
3 Monitoring Youth in Transition with Epilepsy and Seizure Disorders
4 Monitoring sub grant to Children's National Medical Center with Children
5 Collaborating with Children's with the implementation of the HRSA funded pilot program for Family Navigators that will work with families of children with special needs.
6 Monitor, evaluate and counsel sub grantee Advocates for Justice and Education as they develop the DC Parent Information Network.

c. Plan for the Coming Year

1 Continue to collaborate with MCOs
2 Continue to collaborate with Department of Health Care Finance to support increased efforts for well child visits
3 Continue to monitor Youth in Transition with Epilepsy and Seizure Disorders
4 Monitor the sub grant for continuation of Parent Information Network
5 Continue to collaborate with Children's National Medical Center as they implement their HRSA funded pilot program for Family Navigators that will work with families of children with special needs

6 Analyze the specific requirements for a sub grant or contract to re-establish the PRAMS survey

7 Collaborate with DC Family Voices and the DC Parent Information Network to help ensure that community based systems of care are organized and easily available to families of CSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	8	8.5	9	25
Annual Indicator	5.8	5.8	24	24	24
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	25	25	25	25	25

Notes - 2009
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.
2005/2006 Revisions & Changes:
In the 2005-2006 version of the NS-CSHCN, significant wording changes and new additions were made to the set of questions used to assess Transition to Adulthood. The result is an improved and more robust assessment of this important concept. The 2001 version of the outcome is based on CSHCN ages 13-17; the 2005/06 outcome is calculated for CSHCN ages 12-17. Take these changes into consideration when comparing results across survey years. See Additional Notes section below for more details.
Additional Notes:
The Transition to Adulthood summary measure is a composite score derived from two different subparts based on 8 different survey items. Technical expert panel review of the 2001 NS-CSHCN methods for assessing transition to adulthood led to significant revisions and additions to the 2005-2006 version of these questions. In particular, filter questions were added to identify CSHCN who needed the services being assessed and a new question was added to assess whether health care providers help CSHCN to take increasing responsibility for self-care.

The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

Notes - 2008
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.
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Additional Notes:
The Transition to Adulthood summary measure is a composite score derived from two different subparts based on 8 different survey items. Technical expert panel review of the 2001 NS-CSHCN methods for assessing transition to adulthood led to significant revisions and additions to the 2005-2006 version of these questions. In particular, filter questions were added to identify CSHCN who needed the services being assessed and a new question was added to assess whether health care providers help CSHCN to take increasing responsibility for self-care.

Notes - 2007
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

2005/2006 Revisions & Changes:
In the 2005-2006 version of the NS-CSHCN, significant wording changes and new additions were made to the set of questions used to assess Transition to Adulthood. The result is an improved and more robust assessment of this important concept. The 2001 version of the outcome is based on CSHCN ages 13-17; the 2005/06 outcome is calculated for CSHCN ages 12-17. These changes need to be considered when comparing results across survey years.

Additional Notes:
The Transition to Adulthood summary measure is a composite score derived from two different subparts based on 8 different survey items. Technical expert panel review of the 2001 NS-CSHCN methods for assessing transition to adulthood led to significant revisions and additions to the 2005-2006 version of these questions. In particular, filter questions were added to identify CSHCN who needed the services being assessed and a new question was added to assess whether health care providers help CSHCN to take increasing responsibility for self-care.

a. Last Year's Accomplishments
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Additional Notes:

The Transition to Adulthood summary measure is a composite score derived from two different subparts based on 8 different survey items. Technical expert panel review of the 2001 NS-CSHCN methods for assessing transition to adulthood led to significant revisions and additions to the 2005-2006 version of these questions. In particular, filter questions were added to identify

CSHCN who needed the services being assessed and a new question was added to assess whether health care providers help CSHCN to take increasing responsibility for self-care. The next survey began in 2009. Data has not been posted on the website and when the 2009 data becomes available, this measure will be updated.

1. Continued the CSHCN Advisory Board comprised of parents, advocates and providers. Funded 2 parents to attend annual conference.

2. Monitored the Parent Information Network and family navigation sub grants.

3. Continuted to coordinated referrals with OSSE related to special needs such as hearing services.

4. Awarded a sub grant to utilize parent counselors who will help parents navigate the system.

5. Awarded a sub grant to assess the needs of District SHCNs children and develop recommendations/goals. As a result the recomendations include: 1) create a forum for family navigators and care coordinators supporting children and youth with special health care needs and their families from across; 2)analyze D.C. physician survey results on transition and prepare an article or report on transition barriers and opportunities in D.C. 3) conduct a year-long transition learning collaboration with 3 pediatric and 2 adult primary care sites. This work will be done in conjunction with the Center for Medical Home Improvement. 4)With the National Alliance and Family Voices, begin to develop a training/mentoring program for teenage young adults and parents on health care transition. 5) Develop and implement physician training on health care transition, working collaboratively with the local chapters of AAP, AAFP, and ACP and with local academic medical centers, HSCSN, managed care organizations, and DCPCA

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop and implement a coordinated, collaborative approach among public agencies, health care delivery organizations, home visiting programs, the local chapter of the American Academy of Pediatrics and family advocacy and support organizations .			X	X
2. CSHCN Advisory Board			X	
3. Parent Information Network	X		X	
4. Support CNMC Family navigator/Medical Homes program.	X		X	
5. Continued collaboration with Family Voices			X	
6. Continued collaboration with National Alliance			X	
7. Parent Peer Counseling Program			X	
8. Collaboration with OSSE related to SHCN		X		
9. MCH Title V Town Hall meeting			X	
10. Increase provider knowledge about the EPSDT benefits of Medicaid. 2. Implement formal collaboration between the DHCF and other systems building and service agencies to maximize the use of EPSDT benefits.	X	X	X	X

b. Current Activities

1 Monitor Parent Information Network activities
2 Support and participate on the CSHCN Advisory Board
3 Convene and lead the MCH Title V Town Hall Meeting to discuss the Needs Assessment
4 Update Universal Call Center which directs residents to specific services, include health and support services.

5 Collaborate with CNMC as it implements their HRSA-funded Family Navigator Program.
6 Reviewed findings and recommendations of the Needs Assessment.
7 Developed request for a proposal for Parent Information Network.
8 Request CSHCN Advisory Board and invitees to the Town Hall Meeting to review and comment on the draft Title V MCH application for 2011.

c. Plan for the Coming Year

1 Award sub grant to continue activities of Parent Information Network activities.
2 Monitor and provide guidance to sub grantees for Parent Information Network
3 Monitor and provide guidance to sub grantees providing transition services for children with SHCN to adult services.
4 Continue to support the CSHCN Advisory Board.
5 Ensure Universal Call Center has current information as it directs residents to specific services, including health and support services.
6 Continue to collaborate with CNMC as its launches their HRSA funded Family Navigator Program
7 Transition family navigator web site to DOH.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	80	82	82	90
Annual Indicator	73.5	78.4	83.4	72.4	72.4
Numerator					
Denominator					
Data Source				CDC NIS	CDC NIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	92	95	94

Notes - 2009
The 2009 data was not available, so 2008 information is used here. When the data is available this measure will be updated.

Children in the Q3/2008-Q2/2009 National Immunization Survey were born between July 3, 2005 and January 11, 2008.
Estimates are based upon (the immunization schedule) 4:3:1:3:3 plus 1 or more doses of varicella vaccine.

SOURCE: Center for Disease Control and Prevention's National Immunization Survey

http://www.cdc.gov/vaccines/stats-surv/nis/tables/0809/tab02_antigen_iap.xls

Notes - 2008
Children in the Q3/2008-Q2/2009 National Immunization Survey were born between July 3, 2005 and January 11, 2008.

Estimates are based upon (the immunization schedule) 4:3:1:3:3 plus 1 or more doses of varicella vaccine.

SOURCE: Center for Disease Control and Prevention's National Immunization Survey
http://www.cdc.gov/vaccines/stats-surv/nis/tables/0809/tab02_antigen_iap.xls

Notes - 2007
Estimates are based upon 2007 Q3-2006 to q2 007. Children were born between July 2003 and December 2005. ††† 4:3:1:3:3 plus 1 or more doses of varicella vaccine.http://www.cdc.gov/vaccines/stats-surv/nis/tables/0607/tab09_

a. Last Year's Accomplishments
1. Continue to collaborate with DCPS and Charter school nurses to maintain immunization levels for children enrolled in Head Start programs, as well as school aged children.
2. Maintained levels of immunization compliance in Public and Charter schools as well as in licensed child development centers and Head Start centers.
3. Continued the Healthy Start Program that counsels pregnant and parenting women on the importance of childhood immunizations and assists them with access to pediatric services including transportation to and from provider offices.
4. Continued to monitor the Immunization Registry data collection and reporting to ensure that DOH will continue to meet its immunization performance measures.
5. Distributed H1N1 vaccines for children to providers throughout the District.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH collaboration with DHCF to increase well child visits			X	
2. Healthy Start Program	X			
3. Family Support Worker Program	X			
4. Public health campaign " I am a Healthy DC Mom", "I am a healthy DC Baby"	X			
5. Perinatal and Interconceptual Advisory Board -	X			
6. Collaboration with schools and Head Start Programs	X	X		
7. Collaboration with HEPRA re: H1N1 school children protocols including school closures, treatment protocols and vaccines	X	X	X	
8.				
9.				
10.				

b. Current Activities
1 Continues to work with the School Nurses and Administrators of the Public, Charter, Parochial and Private schools to ensure high immunization rates in the face of new regulations. The Immunization Program staff provide data needed to enforce immunization compliance for licensed child development centers and Head Start centers and assure staff at these facilities are informed of the new regulations. Letters are sent to parents and schools announcing the new

immunization requirements.
2 Evaluating the current immunization compliance rates in Private and Parochial schools by working closely with schol nurses and school officials.
3 Assure maintenance of the immunization registry by working with senior officials in the Department of Health.
4 Continue to develop practice based improvement strategies for immunization rates for children 0-4 years of age.
5 Healthy Start program continues its outreach and education of parents.

c. Plan for the Coming Year
1 Continue to work with the School Nurses and Administrators of the Public, Charter, Parochial and Private schools to assure high immunization rates.
2 Develop strategies to ensure current immunization compliance rates in Private and Parochial schools by working closely with school nurses and school officials
3 Assure maintenance of the immunization registry by working with senior officials in the Department of Health.
4 Continue to develop practice based improvement strategies for immunization rates for children 0-4 years of age.
5 Expand the public information campaign "I am a Healthy DC Baby" to include component that includes importance of screenings and immunizations.
6 Continue Healthy Start program outreach and education of parents.
7 Continue to collaborate with HEPRA related to H1N1 or other flu epidemic protocols for school age children, including school closures and vaccine issues.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	34.1	34.1	34.1	32	40
Annual Indicator	37.8	38.4	41.1	40.4	40.4
Numerator	327	372	393	389	389
Denominator	8648	9681	9560	9621	9621
Data Source				DC 2008 Birth File	DC 2008 Birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	35	35	35	35	35

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Currently, the number of births in 2008 among teens ages 15-17 is used to report information for 2009. The 2009 data will

be available in 2011, and this measure will be updated.

The goal of 40 should remain at 32. However it cannot be changed for current or past years. A value of 35 has been chosen fo the next 5 yearrs.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Birth file.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343

Notes - 2008
The birth rate per 1,000 teen mothers ages 15-17 years decreased by 1.7% from a rate of 41.1 births per 1,000 in 2007 compared to 40.4 births per 1,000 in 2008. However, this does not meet the Annual Performance Objective of 32 births per 1,000 teens aged 15-17.

Since 2004, birth rates among this age group have been fluctuating. However, examination of three-year rolling averages shows a slight change in the birth rate for teen mothers ages 15-17: from 39.5 per 1,000 in the period 2004-2006 to 40.0 per 1,000 during the period 2006-2008.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Birth file.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343

Notes - 2007
Source: Numerator is taken from The District of Columbia State Center for Health Statistics 2007 Birth File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

The birthrate (per 1,000) for District teen mothers ages 15-17 years increased by 5.9 percent from a rate of 38.8 percent per 1,000 live births in 2006 to 41.1 percent per 1,000 live births in 2007.

a. Last Year's Accomplishments
1 PIHB continued to collaborate with WIC, Department of Corrections, shelters and school nurses to provide early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance;
2 Continue Health and Sexuality Education Programs at various DCPS and a few Charter Schools as well as the Woodson Adolescent WellnessCenter continue to provide health and sexuality education, comprehensive health services, and pregnancy prevention programs.
3 Collaborated with DHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge with Home Visitation program;
4 Collaborated with HASTA to implement routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant;
5 Enhanced linkage to APRA substance abuse education and treatment services;
6 Enhanced community-based screening and prevention services for at risk families and youth served by child protective service agency;

7 Monitored STD and HIV rates in the District of Columbia and partnered with HASTA, including condom distribution and STD testing in schools.
8 Continued to support the Center services including a comprehensive array of physical and mental health services as well as health education and support services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perinatal and Interconceptual Advisory Board -	X			
2. School Nurse Program	X			
3. School based clinics	X		X	
4. Health and sexuality education classes in DCPS and Charter schools	X	X		
5. Carrera Pregnancy model program, health generations and girl talk programs - mitigate teen pregnancy	X		X	
6. Monitor and update Child Action Plan			X	X
7. Develop Youth Action Plan			X	X
8. Family Support Worker Program	X		X	
9.				
10.				

b. Current Activities
1 Work with community partners to implement evidence based approaches to increase the age of sexual initiation.
2 Established programs and procedures that support adolescent parents including "Girl Talk" and "Healthy Generations."
3 Continue health and sexuality education classes that include addressing pregnancy prevention and self awareness sessions in District of Columbia schools for grades K-12.
4 Continue to support the DCPS "Making Proud Choices Curriculum" for all high school students.

c. Plan for the Coming Year
1 Continue to work with community partners to implement evidenced based approaches to increase the age of sexual initiation including health and sexuality education.
2 Apply for Federal grants that support expansion of more evidence based maternal and child health visitation models.
3 Monitor and evaluate outcomes of sub grants "Girl Talk" and "Healthy Generations."
4 Continue sub grant support for Carrera Pregnancy program model.
5 Continue health and sexuality education classes that include addressing pregnancy prevention and self awareness sessions in the District of Columbia schools for grades K-12 and/or support DCPS implementation of health and sexuality education curriculum in all DCPS and Charter schools.
6 Continue Woodson Adolescent Wellness Center to provide health and sexuality education, comprehensive health services, and pregnancy prevention programs.
7 Add three new high school based clinics that will provide health and sexuality education, comprehensive health services, and pregnancy prevention programs.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	65	65	65	80
Annual Indicator	13.3	3.0	57.6	76.4	72.6
Numerator	108	67	49	311	292
Denominator	812	2259	85	407	402
Data Source				DC 2008 Oral Health Program	DC 2009 Oral Health Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	85	85	85	85

Notes - 2009
Field notes: Year 2009
Numerator: Number of 3rd graders who received a sealant
Denominator: Number of eligible 3rd graders
Data source: DC DOH Oral Health Program

This reporting period, 11 District of Columbia Public Schools were targeted to receive Oral Health services (2 fewer than last year). These schools met treatment inclusion criteria that at least one-half of students enrolled were eligible for the free or reduced lunch program; students also were required to return signed permission slips. As in previous years, the number of eligible students and those who returned permission slips remains low. The rate of returned signed consent forms fluctuates in spite of our best efforts. In 2009, the return rate was 52% for the 11 elementary schools.

The percent of 3rd graders receiving a sealant from the Oral Health program is somewhat lower in 2009 (72.6%) compared to 2008 (76.4%). It does not meet the 2009 Annual Performance Objective of 80 percent 3rd grade children to receive protective sealants on at least one permanent molar tooth.

Notes - 2008
Numerator : Reflects the number of 3rd graders who received a sealant.

Denominator: Reflects the number of eligible 3rd graders

This reporting period, 13 District of Columbia Public Schools were targeted to receive Oral Health Services. These Schools met the criteria that at least one-half of the student enrollment were eligible for free or reduced lunch program.

The number of eligible students are therefore eligile for the free lunch program and those who returned permission slips were included in oral health program.

Notes - 2007

This reporting period, 6 District of Columbia Public Schools were targed to receive oral heath services (2 more than last year). These schools met the criteria that at least one-half of the student enrollment were eligible for the free or reduced lunch program. Therefore, the number of eligible students (including those who returned permission slips) and including those who used the service remained low. In addition, the schools served had overall small enrollment numbers for third grade classes. The denominator reflects the number of eligible 3rd graders; the numerator reflects the number 3rd graders who received a sealant.

In 2006 the denominator was the number of all eligble children. This caused the annual indicator to be much lower, and therefore was not used again in this reporting year.

It can be noted that DC's oral health program is expanding to provide services in all grades in participating elementary schools.

a. Last Year's Accomplishments

This reporting period, 11 District of Columbia Public Schools were targeted to receive Oral Health services (2 fewer than last year). These schools met treatment inclusion criteria that at least one-half of students enrolled were eligible for the free or reduced lunch program. Students also were required to return signed permission slips. As in previous years, the number of eligible students and those who returned permission slips remained low. The rate of returned signed consent forms fluctuates in spite of our best efforts. In 2009, the return rate was 52% for the 11 elementary schools.

The percent of 3rd graders receiving a sealant from the Oral Health program is somewhat lower in 2009 (72.6%) compared to 2008 (76.4%). It also does not meet the 2009 Annual Performance Objective of 80 percent 3rd grade children to receive protective sealants on at least one permanent molar tooth.

1) The Oral Health Division was able to successfully expand the School Based Dental Program (Program) by hiring an additional dentist and a community oral health educator (who also provides dental assistance to the additional dentist). As a result, DC Head Start centers and DC Public Schools (DCPS) elementary school students of all grades who presented their signed parental consent forms were provided with preventive oral health services.

2) Schools with at least 50% of its student population enrolled in the National Free or Reduced Lunch Program are targeted by the Program. Dental services are provided in two schools simultaneously. This Program allows students enrolled in schools that meet this criteria to obtain necessary dental services they would not otherwise be able to access.

3) The Department of Health Care Finance increased its reimbursement rates to 100% of Medicare for medical and dental providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral health exam and sealant program	X	X		
2. Oral health education	X	X		
3. Monitor Child Action Plan Oral Health activities for compliance		X	X	
4. Continue to support expanding the role of dental hygienists to practice independently	X		X	X
5. DHCF increased benefits in Alliance program to cover oral health			X	X
6. Develop Oral Health State Plan			X	X

7. Strategies to increase parent consent for school based oral health services	X		X	
8.				
9.				
10.				

b. Current Activities

1) Preventive dental services:

Sealant Application - Sealants are thin plastic materials that are applied to the chewing surfaces of permanent molars; they are most effective in reducing cavities in children with newly formed permanent teeth as usually found in 2nd and 3rd graders (6 - 8 years)

- Fluoride Treatment - Fluoride treatment is used as a preventive measure because it is absorbed into the enamel of the teeth making them more resistant to acid producing bacteria
- Dental Screenings - Helps to build a positive attitude in the student towards dental health, encourage parents to schedule dental examinations for their child, and be used to enhance the health education program
- Oral Health Education & Promotion - Inform students, parents and teachers of the importance of good oral health and advice them on techniques to prevent oral diseases
- Data Collection - The Project serves as a valuable source of original oral health data as the Division, in conjunction with the DC DOH and the District at large, continues to build its oral health data.

2) Oral Health Program continues its efforts to allow Dental Hygienists to practice independently in the District.

c. Plan for the Coming Year

1) School-Based Dental Program -- Referral Program

The Division will aim to increase its efforts to more effectively ensure that parents and guardians are alerted when their child is in need of additional dental care and provide the child and parent with information of possible dental practitioners they may visit.

2) Continue Sealant Application and Data Collection - for 2nd and 3rd graders (6 - 8 years)

- Fluoride Treatment
- Dental Screenings
- Oral Health Education & Promotion
- Data Collection

3) Continue to monitor and evaluate the Oral Health Program activities in the DC Child Health Action Plan.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	2	2	2	3
Annual Indicator	0.0	4.2	3.2	1.1	1.1
Numerator	0	4	3	1	1
Denominator	96217	95176	93980	92412	92412
Data Source				2008 DC Death File (Vital	2008 DC Death File (Vital Statistics)

				Statistics)	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	Yes
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2	2	2	2	2

Notes - 2009
The District has a 2-year delay in reporting death data. Currently the number of deaths in 2008 among infants and children aged 1-14 caused by motor vehicle crashes is used to report information for 2009. The 2009 data will be available and reported in 2011.

A goal of 3 should logically be changed to 2 as reflected in upcoming years. However it cannot be changed in the system for this current year.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death File.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Notes:

The death rate among children 1-14 years old caused by motor vehicle crashes has decreased from 3.2 deaths caused by motor vehicle accidents per 100,000 children in the District in 2007 to 1.1 motor vehicle related deaths per 100,000 children in the District in 2008. An examination of the three year trends shows a marked decrease from 4.2/100,000 in 2006, 3.2/100,000 in 2007 and 1.1/100,000 in 2008.

Notes - 2008
The District has a 2-year delay in reporting death data. Currently the number of deaths in 2008 among infants and children aged 1-14 caused by motor vehicle crashes is used to report information for 2009. The 2009 data will be available and reported in 2011.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death File.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Notes:

The death rate among children 1-14 years old caused by motor vehicle crashes has decreased from 3.2 deaths caused by motor vehicle accidents per 100,000 children in the District in 2007 to 1.1 motor vehicle related deaths per 100,000 children in the District in 2008. An examination of the three year trends shows a marked decrease from 4.2/100,000 in 2006, 3.2/100,000 in 2007

and 1.1/100,000 in 2008.
*Denominator does not include 2008 births.

Notes - 2007
Source: Numerator: The District of Columbia, State Center for Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Within the District, although our numbers for deaths to children aged 14 years and younger remain low ,but still above our annual performance objectiv of no more than 2 deaths per 100,000 children due to motor vehicle accidents. On average the District of Columbia has a low number of deaths within this age range due to motor vehicle accidents.

a. Last Year's Accomplishments
CHA through the Child Health Action Plan evaluated strategies to address the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children through an analysis of policies and programs currently in place.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue analysis of appropriate policies and programs for violence and injury prevention including motor vechicle crashes	X	X		
2. Initiate monitoring of truancy rates which leads to at risk youth behaviors			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Reviewing the Child Health Action Pan strategies to address the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children through an analysis of policy and programs currently in place.

c. Plan for the Coming Year
1. CHA will review and consider amending the Child Health Action Plan to incorporate strategies to address the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children as well as self inflicted injuries or suicide through an analysis of policies and programs currently in place.
2. Identify opportunities to collaborate with DC Public Schools and the community to address truancy rates, which are tied to violence and at risk family, social and health issues.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		40	41	42	25
Annual Indicator	34.6	28.8	21.8	23.0	28.6
Numerator		1352	375	486	590
Denominator		4695	1722	2113	2063
Data Source				WIC DCPedNSS System	WIC PedNSS System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	25	25	25	26	27

Notes - 2009
Source: 2009 DC Pediatric Nutrition Surveillance System (PedNSS). This data reflects:

Change in performance objective reflects the change in data source used to the calculate percent. 2008 goal was 42 and 2009 goal was 25.

Numerator: Breastfeeding rates for the District of Columbia's WIC population, are the percent of infant s wh0 are being breastfed at 6 months of age. Data obtained from the Pregnancy Surveillance System (PNSS).

Denominator: Total women asked question.

Emphasis on number of infants breastfed not the number of moms reporting breastfeeding. The information is updated every 3 months when checks are retrieved (that is, if participant is participating in the program and is not merely enrolled).

Notes - 2008
Source: 2009 DC PEDNSS system.
Pediatric Nutrition Surveillance System (PedNSS)

Numerator: Breastfeeding rates for the District of Columbia's WIC population of women with infants who report breastfeeding at six months of age

Denominator: Total women asked question.

Emphasis on number of infants breastfed not the number of moms reporting breastfeeding. The information is updated every 3 months when checks are retrieved (that is, if participant is participating in the program and is not merely enrolled).

Notes - 2007
Source: FY 2007 DC Cares-Women Infants Children (WIC) Data base. This data reflects the breastfeeding rates for the District of Columbia's WIC population of women with infants who report breastfeeding at six months of age.

In the previous year the numbers were an estimate based upon the Pediatric Nutrition Surveillance Program national phone survey on breastfeeding. Reporting actual numbers of serviced clients was deemed to be preferred over numbers taken from a phone survey.

a. Last Year's Accomplishments

1 Continued the DC WIC breastfeeding program that includes a breastfeeding coordinator at the State level, and a lactation consultant and breastfeeding peer counselors at the Local level.

2 Distributed to eligible WIC participants: breast pumps, education, and support, either one-on-one, or as a group.

3 Continued to convene monthly Breastfeeding Beautiful Beginning Club meetings.

4 Collaborated with the DC Breastfeeding Coalition to establish breastfeeding friendly hospitals. Karen Watts Director of Perinatal and Infant Health Bureau is the CHA representative on the Coalition.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC Program supports breast feeding	X			
2. Hospital discharge program	X	X		
3. Healthy Start Case Management Program	X		X	
4. Support Breast Feeding Peer Counseling program	X			
5. Representation on DC Breast Feeding Coalitition			X	
6. Continue Lactation Room located at DOH	X			
7. Develop strategies to promote breast feeding rooms in work place			X	
8.				
9.				
10.				

b. Current Activities

1 Continues operating the Lactation Unit and Resource Center and collecting data on breastfeeding mothers. The unit will be evaluated to include more sharing opportunities for mothers to bond. A survey of all users will be available on site to document center use, and satisfaction with the service.

2 Continues the breastfeeding program through the WIC Program that includes a breastfeeding coordinator at the State level, and a lactation consultant and breastfeeding peer counselors at the Local level.

3 Distributes to eligible WIC participants breast pumps, education, and support, either one-on-one, or as a group.

4 Convenes a monthly "Breastfeeding Beautiful Beginning" Club meetings.

5 Continues collaboration with DC Breastfeeding Coalition to establish breastfeeding friendly hospitals.

6 Provided lactation training to Healthy Start nurses.

c. Plan for the Coming Year

1 Continue operating the Lactation Unit and Resource Center and continue to collect data on breastfeeding mothers.

2 Continue breastfeeding program through the WIC Program that includes a breastfeeding coordinator at the State level, and a lactation consultant and breastfeeding peer counselors at the Local level. Expand peer counselors.

3 Continue distribution to eligible WIC participants breast pumps, education, and support either one-on-one, or as a group.
4 Continue to convene monthly Breastfeeding Beautiful Beginning Club meetings.
5 Continue to collaborate with DC Breastfeeding Coalition to establish breastfeeding friendly hospitals.
6 Collaborate with PIHB to develop a breast feeding module for the social marketing campaign "I am a healthy DC baby".
7 Develop strategies to require businesses to provide reasonable space for breast feeding in accordance with the amendment to the Fair Labor Standards.
8 Continue to provide lactation training to new Healthy Start staff.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	75	75	80	98
Annual Indicator	25.5	22.6	34.6	97.9	67.6
Numerator	3871	3175	5452	14199	10484
Denominator	15179	14065	15752	14500	15500
Data Source				AURIS	AURIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	98	98	98

Notes - 2009
2009 newborn hearing data was obtained from the AURIS database system used by CHA. 15,149 screens were reported for 10,484 children with 2009 DOBs. The number of dulicate records ranged freom 1 - 36. Of this group 9,500 children had a single record, while 984 newborns had 5,649 records of screenings.

The tracking system continues to generate duplicate records as occurred last year.

Notes - 2008
2008 newborn hearing data was obtained from the AURIS database and reporting system. 14,199 screening occurred in 2008. Review of data in both 2007 and 2008 indicate that there are numerous duplicate child records in the system.

The program is working with the contractor is taking steps to eliminate or reduce the number of duplicate records in the system. After removing dulicate records it was found that the information system has data on reported screenings at levels similar to last year.

2008 Birth data is provided by State Center for Health Statistics and is their most recent estimate of all births in the District of Columbia.

Notes - 2007

2007 newborn hearing data was obtained from the AURIS database and linked with the 2007 birth file. Not all birthing facilities have the resources to input directly into the information system.

The program obtains data directly from the hospitals and indicates that 14,995 tests were taken of children born in 2007. It is unclear what is the discrepency between the data reported by the sites and the data inputed into the information system.

a. Last Year's Accomplishments

1 Continued efforts to assist facilities to purchase and replace current hearing screening equipment that do not require interpretation by an audiologist to facilitate referral process..

2 Continued working with Vital Records to ensure collection of data in birth records. Title V funds used to update the Vital Records data collection requirements.

3 Provided referral services and follow-up for infants with positive hearing screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perinatal Advisory Board			X	
2. DC legislation requiring metabolic and hearing screens at the time of birth			X	
3. Referral of newborns with positive hearing screen to OSSE for follow-up and coordination of care	X			
4. Replacement of current screening equipment to an FDA - pproved device that does not require interpretation of screening results by an audiologist	X		X	
5. Public Health Campaign - " I am a Healthy DC Mom" has a screening component and new campaign "I am a healthy Dc baby."			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1 Encourage hospitals and birthing centers to replacing current hearing screening equipment to improve referral process.

2 Working to increase data verification of screenings by partnering with Vital Records.

3 Continue to collaborate with OSSE to ensure follow-up in timely manner of infants referred because of positive hearing screen

4 Increase parent's knowledge of hearing loss by providing educational material.

5 Continue to distribute new brochures to hospitals containing information for parents about failed initial hearing screening.

6 Increasing the integration with the medical home by identifying the Pediatrician or Primary Care Provider prior to discharge.

7 Partnering with the DC hospitals to identify and verify the newborn's primary care provider prior to discharge.

8 Ensuring appropriate developmental progress for children with hearing loss through collaboration with providers and parents.

9 Working to increase parents and childcare providers' knowledge of hearing screening

10 Coordinating care by partnering with the Infants and Toddlers with Disability Division (ITDD). The Bureau, in collaboration with ITDD and the Special Education units at DCPS and

OSSE, will monitor and co-manage children 0 to 3 years of age referred with hearing loss.

c. Plan for the Coming Year

1 Increase parents and childcare providers' knowledge through education on developmental milestones.

2 An Audiologist will educate and conduct training sessions for parents and early child care providers regarding age-appropriate milestones for speech and language development.

3 Increase coordination of care by partnering with the Infants and Toddlers with Disability Division (ITDD).

4 The Bureau, in collaboration with ITDD and the Special Education units at DCPS and OSSE, will continue to monitor and co-manage children 0 to 3 years of age referred with hearing loss.

5 Continue to working with Vital Records to ensure collection of data in birth records. Title V funds will be used to update the Vital Records data collection requirements.

6 Encourage changing hearing screening equipment in all hospitals and birthing centers.

7 Continue to collaborate with OSSE to improve follow-up timeframe for infants with a hearing loss.

8 Continue medical home integration project for children with special needs.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	6
Annual Indicator	6.9	7.8	7.8	8.0	6.8
Numerator	7697	9221	9221	9090	7600
Denominator	111967	118104	118104	113720	111971
Data Source				State Health Facts and Census data	State Health Facts and Census data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6	5	5	5	5

Notes - 2009

Numerator: 2007-2008 District of Columbia: Health Insurance Coverage of Children 0-18, states (2007-2008), U.S. (2008)
http://www.statehealthfacts.org/profileglance.jsp?rgn=10

Denominator: The Untied States Census Bureau, 2008 American Community Survey Population Estimates for the District of Columbia.
http://factfinder.census.gov/servlet/DTTable?_bm=y&-context=dt&-

ds_name=ACS_2008_1YR_G00_&-mt_name=ACS_2008_1YR_G2000_B01001&-CONTEXT=dt&-tree_id=308&-geo_id=04000US11&-search_results=01000US&-format=&-_lang=en

Notes - 2008
Numerator: 2007 District of Columbia: Health Insurance Coverage of Children 0-18, states (2006-2007), U.S. (2007)
www.stateheathfacts.org

Denominator: The Untied States Census Bureau, 2007 American Community Survey Population Estimates for the District of Columbia.
http://www.census.gov/popest/states/asrh/tables/SC-EST2007-02-11.xls

Notes - 2007
Data for 2007 is not available, when it becomes available, this measure will be updated.

a. Last Year's Accomplishments
1 Continued the Healthy Start and MOM unit programs
2 Continued the expanded Family Support Worker program that conducts outreach to pregnant and parenting women and assists with enrollment to entitlement programs.
3 Expanded collaboration with DC Jails and Shelters to identify pregnant women

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start Program refers pregnant women and new moms to appropriate benefit and entitlement services	X			
2. DC Alliance provides health care coverage to those that do not meet eligibility requirements			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1 Continues the Healthy Start, MOM unit and other outreach programs to enroll eligible pregnant and parenting women in insurance and other entitlement programs.
2 Expanding its collaboration with DC Jail and Shelters.
3 Continuing collaboration with DHCF for early indemnification of pregnant women by Medicaid and Alliance entitlements.

c. Plan for the Coming Year
1 Healthy Start, MOM unit and other outreach programs to enroll eligible pregnant and parenting women in insurance and other entitlement programs.
2 Continue to collaborate with DC Jail and Shelters to identify pregnant and parenting women.
3 Continue to collaboration with DHCF for early identification of pregnant women by

Medicaid and Alliance entitlements
4 CHA will request technical assistance to collaborate with Medicaid on implementing the Katy Beckett waiver to provide emergency funds to parents of special needs children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		13	13	12	12
Annual Indicator	12.8	14.6	14.6	33.6	28.6
Numerator		812	791	1820	1928
Denominator		5563	5419	5419	6742
Data Source				DC PedNSS 2008	DC PedNSS 2009
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	12	12	12	15

Notes - 2009
Source: District of Columbia PedNSS 2009.

Numerator information:
Information broken down into two groups:
Percentile
=>85th to <95th >95th >=85th Percentile

1,011 + 917 = 1,928 (total)

Denominator: All children in WIC between ages 2 to 5 years.

Notes - 2008
Source: District of Columbia PedNSS 2008.

Numerator information
Information broken down into two groups:
Percentile
=>85th to <95th >95th >=85th Percentile

997 + 823 = 1,820 (total)

Denominator: All children in WIC between ages 2 to 5 years.

Information under reported in 2007. Information in 2007 was for children ages 2 to 5 years falling into th 85-95th percentile.

Notes - 2007
We currently have only the PedNSS 2007 available. 2008. This information is based on WIC Children. When new information becomes available ths measure will be updated.

a. Last Year's Accomplishments
1 DC Obesity Inter-Agency Work Group was initiated to gather information about obesity prevention activities of DC government.
2 The Workgroup developed the State Plan on Childhood Obesity.
3 Nutrition and Physical Fitness Bureau continued:
a. the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
b. to support the DC Action for Healthy Kids - is a volunteer-based group of local stakeholders committed to creating a healthier school environment for youth and children in D.C. by engaging schools in actions that foster sound nutrition.
c. To support the Preventive Service Block Grant supported expansion of "I'm Moving I'm Learning" Program to all the Child Development Centers.
d. the Healthy Corner Store Initiative, researching ways and developing social marketing materials to increase access to healthy foods in Ward 8 corner stores;
e. the Sister Circles, piloted in Wards 5,6,7, and 8 as a vehicle for supporting African American women 40-70 years of age to reduce stress, improve eating habits, and exercise more.
4 New food vendor contract was signed that includes improved nutritional school meals.
5 Expanded the Farmers Markets
6 Promoted breast feeding and lactation

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expansion of "I am Moving, I am Learning" fitness program to all child development centers	X			
2. Public Health Campaign - " I am a Healthy DC Mom"			X	
3. Partnership with DCPS and OSSE resulted in adding physical education to school and after school program curriculum	X	X		
4. New food vendor contract that includes improved nutritional school meal programs		X	X	
5. Local funds continue to support grants to address childhood obesity	X		X	
6. Implement State Plan on Childhood Obesity		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
1 Collaborating with Department of Health Care Finance (DHCF) to assure adequate access to care for individuals with obesity or at-risk for obesity. CHA is working with Medicaid to rectify these issues in FY 2009.
2 The Childhood Obesity State Plan was published in Oct 2009. DOH is also developing a State Plan on Obesity Prevention and Reduction, in collaboration with the citywide Obesity Work Group. The State Plan was created with substantial engagement from key stakeholders, and will include structured community dialogues, focus groups, and other mechanisms to ensure significant input from District residents and other stakeholders. Recent news articles reported that in the National Capital Area, the District ranked third in obesity rates behind Maryland and Virgina.

3 Improving quality of primary care services for identification, treatment and prevention of obesity by implementing a quality improvement initiative. DOH partnering with Medicaid in the development and conduction of Obesity Primary Care Quality Improvement Training Program. This includes facilitating the dialogue between the MCOs and Medicaid in how to develop an evidence-based quality improvement initiative to encourage identification, prevention and treatment of obesity in children and families.

c. Plan for the Coming Year

1 Continue to collaborate with DHCF to assure adequate access to care for individuals with obesity or at-risk for obesity.
2 Publish and distribute the Childhood Obesity Prevention and Reduction Plan.
3 Continue to collaborate with DCPS, OSSE and child development centers to promote nutrition and physical education.
4 Continue to collaborate with DHCF to promote comprehensive services for children and related funding.
5 Collaborate with PIHB to develop 'I am a healthy DC baby" module related to breast feeding and nutrition.
6 Continue the 2010 initiatives:
a. " I am Moving I am Learning" curriculum, a nationally recognized and tested system of physical activity and nutrition services improvement in child development center;
b. the Healthy Corner Store Initiative, researching ways and developing social marketing materials to increase access to healthy foods in East of the River (Wards 7 and 8) corner stores;
c. Sister Circles, piloted in Wards 5,6,7, and 8 as a vehicle for supporting African American women 40-70 years of age to reduce stress, improve eating habits, and exercise more.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Notes - 2009

Currently the District of Columbia Birth Certificate does not collect smoking data per trimester of pregnancy. However, The pilot for the implementation of the 2003 Birth Certificate started in Jan of 2009 and full implementation is now in effect as of the end of March 2009. In the future the District will have the capacity to collect and report on smoking by trimester.

Notes - 2008

Currently the District of Columbia Birth Certificate does not collect smoking data per trimester of pregnancy. However, The pilot for the implementation of the 2003 Birth Certificate started in Jan of 2009 and full implementation is now in effect as of the end of March 2009. In the future the District will have the capacity to collect and report on smoking by trimester.

Notes - 2007

We do not collect smoking data per trimester of pregnancy.

a. Last Year's Accomplishments

1. Continued to provide counseling pregnant and parenting women on health effects of cigarette smoking by Healthy Start case managers and family support workers.
2. Continued to work with community agencies, United Medical Center -- Breathe --DC and IMPACT DC and American Lung Association of DC (ALADC) and APRA in support of smoking cessation.
3. Vital Records forms were updated to accurately capture smoking data.
4. Continue to work with community agencies, ALADC and APRA in support of smoking cessation.

5. The new birth certificate collects alcohol consumption, as well as smoking in the last trimester of pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Public Health Campaign - " I am a Healthy DC Mom" - discusses issues to keep mom and baby healthy			X	
2. Healthy Start case management program counseling pregnant women not to smoke	X	X		
3. Family Support Worker program supports counseling program	X		X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1 Continue counseling pregnant and parenting women on health effects of cigarette smoking.

2 Continue to work with community agencies, ALADC and APRA in support of smoking cessation.

3 Continue to use new birth certificate to collect smoking and alcohol consumption data in the last trimester of pregnancy

c. Plan for the Coming Year

1 Continue counseling pregnant and parenting women on the health effects of cigarette smoking.

2 Continue to work with community agencies, ALA DC and APRA in support of smoking cessation.

3 Continue to collect smoking as well as alcohol consumption in the last trimester of pregnancy from the revised birth certificate (Vital Records)

4 Continue the public information campaign "I am a Healthy DC Mom" and "I am a Healthy DC Baby.", which will also educate women on the impact of smoking during pregnancy and impact on infants and children.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	6	6	5	5	3
Annual Indicator	2.6	0.0	2.5	2.3	2.3
Numerator	1	0	1	1	1
Denominator	38600	39628	40355	44114	44114

Data Source				DC 2008 Death Data (Vital Statisitcs)	DC 2008 Death File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	3	2	2	2

Notes - 2009
The District of Columbia has a 2-year delay for reporting death data. Currently, the number of suicides in 2008 among youth ages 15-19 is used to report information for 2009. The 2009 data will be available in 2011, and this measure will be updated.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death file.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343

Notes - 2008
Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death file.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Deaths due to suicide among youths aged 15-19 (n = 1) continues to remain low in the District of Columbia.

Notes - 2007
The number of suicide deaths among youth , where in the death certificate lists cause of death as suicide, consistently remains low in the District of Columbia.

Source: Numerator: The District of Columbia, State Center for Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

a. Last Year's Accomplishments
/2011/ The District of Columbia has a 2-year delay for reporting death data. Currently, the number of suicides in 2008 among youth ages 15-19 is used to report information for 2009. The 2009 data will be available in 2011, and this measure will be updated.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death File.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Deaths due to suicide among youths aged 15-19 (n = 1) continues to remain low in the District of Columbia. The rate of 2.3 per 100,000 in 2008 is lower than the Annual Performance Objective of 5 per 100,000 established for this measure.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Analysis of policies that mitigate suicide deaths among youth			X	
2. Collaborate with school nurse program to identify opportunities to identify youth with self destructive tendencies, cutting, attempted	X			
3. Devlop Youth Action Plan			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The number of deaths from suicides cannot be reported because the DC State Center for Health Statistics has not released the number of deaths in 2008. The 2008 data is repeated.

The number of homicides in the District far out passes the number of suicides. However we cannot tell how many homicides was the result of a suicidal pact i.e. having someone else kill you rather than you kill yourself. There is no agency that collects this information.

The current activities include but are not limited to:

1 Periodically monitor the number of suicides among youth.

c. Plan for the Coming Year

1. Continue collaborative efforts with the school nurse program and Department of Mental Health and APRA to identify at-risk teens with suicidal ideation.
2. Identify and collect from the data source number of youth with diagnosis and/or treated with diagnosis of suicidal ideation.
3. Develop Youth Action Plan and include goals and objectives to address youth violence, including self inflicted.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	80	80	80	80	80
Annual Indicator	79.0	81.6	76.0	76.1	76.1
Numerator	169	177	196	178	178
Denominator	214	217	258	234	234
Data Source				2008 DC Birth File	2008 DC birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	80	81	82	83

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Notes - 2008
Numerator: Number of very low birth weight infants (<1500 grams) delivered at District hospitals with neonatal intensive care units.
Denominator: Total number of very low birth weight infants (<1500 grams)
Data source: The District of Columbia State Center for Health Statistics 2008 Birth file.

Very low birth weight infants (<1500 grams) delivered at District hospitals with neonatal intensive care units increased by less than 1 %, from 76.0 percent in 2007 compared to 76.1 percent in 2008. However, this measure is lower compared to previous years 2004 through 2006 (76.8%; 79.0%; 81.6%, respectively) and does not meet the Annual Performance Objective of 80% established for this measure.

Notes - 2007
The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates increased from 81.6 percent in 2006 to 99.0 percent in 2007, an increase of 21.3 percent.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The numerator reflects the number of very low birth weight infants delivered at District hospitals with neonatal intensive care units were included.

The denominator reflects the total number of District very low birthweight births.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
1 Supported the "Faces of Our Children" program that supports Sickle Cell families in decision making at each level of their child's care. This local partnership with Howard University focuses on Sickle Cell parents who are a high risk group, and educates teens about the importance of genetic counseling services before conception.
2 Monitored and guided the sub grantees of the Parent Information Network grant which was to make resources available on various conditions including the risks of low birth weight and high risk births.

3 Monitored the Epilepsy program that provides education to parents about epilepsy and high risk deliveries.
4 Provided breasting feeding training to Healthy Start staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start case management services	X			
2. Family Support workers in Wards 5,6, 7, 8	X			
3. Home visitation legislation requiring home visits within first 48 hours of delivery	X			
4. Public Health Campaign - " I am a Healthy DC Mom" - discusses issues to keep mom and baby healthy			X	
5. Outreach programs to pregnant women incarcerated in DC Jail	X			
6. Outreach programs to pregnant women living in shelters	X			
7. Health Start Conference to discuss healthier pregnancy outcomes and strategies			X	
8.				
9.				
10.				

b. Current Activities

1. Evaluating and guiding the current Parent Infant Network vendor's ability to meet objectives and outcomes and expand from the pilot phase to implementation phase.
2. Continued to monitor the Parent Information Network grants, which was to make resources available on various conditions including the risks of low birth weight and high risk births like that lead to a child born with a disability.
3. Continued the Epilepsy program that provides education to parents about epilepsy and high risk deliveries. Youth in Transition with Epilepsy focus groups conducted to identify self care needs of youth and concerns of parent.
4. Continued the funding for Sickle Cell program focused on counseling and education of residents with sickle cell trait and disease.

c. Plan for the Coming Year

1. Award a sub grant to continue to continue the Parent Infant Network to include expansion of navigation services to families with children with special needs; help desk, or resource directory of state and regional services for children with special health care needs, peer mentoring and support activities, etc.
2. Award a sub grant to increase capacity of parents of children who were born with a disability (which can occur to low birth weight babies) to identify and access relevant resources to help the child.
3. Continue collaboration with APRA to support treatment and recovery for pregnant women to mitigate the likelihood of low or very low birth weight babies due to exposure to drugs, alcohol, and cigarettes during pregnancy.
4. Continue collaborations to identify mothers who need WIC services in order to support mothers of lower socioeconomic status that are more likely to have poorer pregnancy nutrition, inadequate prenatal care, and pregnancy complications.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	77	78	78	80
Annual Indicator	77.0	75.0	73.0	74.7	74.7
Numerator	5409	5503	5642	6103	6103
Denominator	7025	7339	7731	8172	8172
Data Source				2008 DC Birth File	2008 DC birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	80	82	83	84

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Notes - 2008
Numerator: Number of infants born to pregnant women who received prenatal care in the first trimester.
Denominator: Number of infants born to women where entry into prenatal care was recorded (does not include 963 missing cases for which prenatal care was not reported).
Data source: The District of Columbia State Center for Health Statistics 2008 Birth file.

Women who received prenatal care in the first trimester increased by 2.3%, to 74.7 percent in 2008 compared to 73.0 percent in 2007, but does not meet the Annual Performance Objective of 78% established for this measure. This indicator evidenced a moderate yet steady decrease for the period 2004-2007 and this is the first year to show improvement.

Notes - 2007
The percent of infants born to women receiving prenatal care in the first trimester decreased from 75 percent in 2006 to 73 percent in 2007, a decrease of 2.6 percent.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The numerator reflects the number of women that reported recieving prenatal care in the first trimester.

The denominator reflects the number of District women that indicated when their prenatal care began.

a. Last Year's Accomplishments
1. Continued to increase oversight and effectiveness of the Healthy Start program's nurse case management component.
2. Expanded recruitment, training and deployment of new Family Support Workers under the Healthy Start program to provide complementary support services that address psycho-social risk

factors affecting pregnant and parenting women and their children.
3. Designed and launched "I am a Healthy DC Mom", a public information campaign.
4. Collaborated with DC Jails and shelters to increase early identification of pregnancy and ensure timely enrollment in prenatal care (PNC) for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.
5. Collaborated with DHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge.
6. Collaborated with HASTA to expand routine prenatal HIV testing and treatment to prevent perinatal HIV transmission to the infant.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Healthy Start case management services	X			
2. Family Support workers in Wards 5,6, 7, 8	X			
3. Home visitation legislation requiring home visits within first 48 hours of delivery			X	
4. Public Health Campaign - " I am a Healthy DC Mom" - discusses issues to keep mom and baby healthy	X			
5. Outreach programs to pregnant women incarcerated in DC Jail	X			
6. Outreach programs to pregnant women living in shelters			X	
7. Healthy Start Conference and FASD program			X	
8.				
9.				
10.				

b. Current Activities

1. Continues to increase oversight and effectiveness of the Healthy Start program's nurse case management to encourage PNC in subsequent births.

2. Continues to recruit, train and deploy new Family Support Workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.

3. Continues to implement the public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive pre-conception and prenatal Care in ensuring a healthy pregnancy, birth, and infancy.

4. Continues early identification of pregnancy and ensure timely enrollment in PNC for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.

5. Collaborates with DCHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge.

6. Continues efforts with HASTAA to promote routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant.

7. Enhancing linkage to mental health and substance abuse education and treatment services, to increase the number.

8. Convened a focus group to discuss access to prenatal care in first trimester.

c. Plan for the Coming Year

1. Evaluate the effectiveness of the Healthy Start program's nurse case management component.

2. Continue, as needed to recruit, train and deploy new Family Support Workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.

3. Continue and expand the public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive pre-conception and prenatal care in ensuring a healthy pregnancy, birth, and infancy. The new module will be called "I am a healthy DC baby."

4. Continue the early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.

5. Continue to collaborate with DHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 Month post-discharge.

6. Continue to collaborate with HASTA to ensure routine prenatal HIV testing and treatment.

7. Continue to collaborate with DMH and APRA to refer pregnant women and families to mental health and substance abuse education and treatment services, to ensure PNC is included in services.

8. Continue to collaborate with shelters to facilitate outreach and Linkages to care for homeless pregnant women who may not receive PNC early.

9. Continue to support and participate in the Perinatal and Infant Health Advisory Group to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities.

10. Report findings from the focus group on access to first trimester prenatal services.

D. State Performance Measures

State Performance Measure 2: *Percent of Medicaid enrolles receiving EPSDT screening*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	78	78	80
Annual Indicator	76.8	77.4	73.6	70.2	68.3
Numerator	54062	53636	52259	52289	55607
Denominator	70427	69320	71013	74441	81471
Data Source				Medicaid Form 416	Medicaid 416 Report
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	80	80	80	

Notes - 2009

Data taken from the 2009 Medicaid 416 Report, prepared by the Centers for Medicare & Mediciad Services by the Department of Health Care Finance.

Numerator taken from Line 9 Total of the report
Denominator taken from Line 8 Total

Notes - 2008

Data taken from the 2008 Medicaid 416 annual report.

Numerator is taken from Row 8: Total eligible who should receive at least one initial or periodic screen.

The denominator is taken from Row 9: Total eligible receiving at least one initial or periodic screen.

DC and MAA are collaborating on the EPSDT well child registry and this should help achieve the annual performance objective.

Notes - 2007
Data obtained from national Medicaid Report Form 416: Annual EPSDT Particpation Report.

Numbrator is row 8: Total eligibile who should receive at least one initial or periodic screen.

The denominator is row 9: Total eligible receiving at least one initial or periodic screen.

DC and MAA are collaborating on the EPSDT well child registry and this should help achieve the annual performance objectivel.

a. Last Year's Accomplishments
/2011/ There has been a small but steady increase in the percentage of Medicaid enrollees less than one year old who received at least one initial periodic screen, from 78 % in 2008 to 80 percent in 2009. DOH has sustained efforts to promote well-child visits in its various programs.

The CASH Bureau continued:
1) to provide comprehensive age appropriate health care and health education to students in DCPS and Charter schools
2) oversight of the school nurse program including identification of additional health education programs that will promote healthy life styles.

The Perinatal and Infant Health Bureaus continued its work with sister Bureaus and DHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, including the first two visits at 48 hours and 1 month post-discharge with the participating managed care organizations (MCO) and expansion of the Family Support Worker program.

Data collection from Shaw Junior High School Hearing and Vision Center will be utilized to support the District's success in meeting national and state performance requirements related to EPDST reporting requirements and special health care needs.

Schools and parents were informed of significant changes in immunization requirements for school age and younger children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide health education in school settings to students		X	X	
2. Provide school nurse program			X	X
3. Family support worker program	X			
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

1. Continued Bureau inter and intra agency collaborations to promote well child assessments.

2. Developed and distributed new immunization requirements to parents and schools and child development programs.

3. Continued oversight of school nurse program.

Challenges: Medicaid and the DC Health Care Finance Administration are no longer are a part of DOH. THerefore getting Medicaid support for data has been a challenge at best.

c. Plan for the Coming Year

1. Continue Bureau inter and intra agency collaborations to promote well child assessments.

2. Monitor and support implementation and compliance with new immunization requirements for school age and child development programs.

3. Continue oversight of school nurse program.

State Performance Measure 3: *Prevalence of lead levels > 10 ug/dL among chldren through age 6*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.9	1.9	1.9	1.9	1.9
Annual Indicator	1.3	1.8	1.3	0.6	0.6
Numerator	200	294	178	81	79
Denominator	15121	15958	13851	13653	13782
Data Source				DC 2008 Lead Trax Database	DC 2009 Lead Trax Database
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1.5	1.5	1.5	1.5	

Notes - 2009

Total of 14,476 blood lead test results for children under the age of six was received and processed by the Childhood Lead Poisoning Prevention Program (CLPPP), representing a total of 13,782 unduplicated children under the age of six who received at least one blood lead test during the 2009 calendar year

Notes - 2008
2008 Data is obtained from the Lead Trax information system. Currently there is a continued decrease in the number of children with elevated lead blood levels.

Notes - 2007
Data is obtained from the Lead Trax information system.
The numerator reflects the number of children <6 with elevated lead levels > 10 ug/dL .

The denominator is the total number of children < 6 screened.

a. Last Year's Accomplishments
1) DDOE Lead Program has flexibility to follow up and send an inspector to look for lead hazards. The draft notice of violation and lead poison hazard is sent to DDOE and the follow-up is conducted. A report is then sent to DCRA and the landlord or owner is notified. DCRA followed up with compliance.

2) DOH Bureau Collaborations - the Lead Safe DC (National Nursing Centers Consortium) receives referrals and briefs the client thru one on one education. Dust is evaluated and if the home is positive they return and clean using specialized equipment

3) CFSA - refers properties to DDOE that will serve a child (on an emergency basis). The house must be safe from lead dust. The exception is if the child is placed with a family member.

4) AARA is funding a weatherization and energy program to replacement of doors and windows to decrease lead dust.

5) School Nurses -- submits to DDOE the health form if the lead test question is blank.

6) Lead Mobile Van is serving the underserved communitiees (Asiain community was chosen).

7) DC Lead legislations --
- Defined lead based paint hazard definition. Included any peeling in a pre 1978 structure it assumes it is lead based hazard. Visual -- soil and dust soil. Issues a report
- Enforcement and inspections -- broad leeway given to DDOE.
- Follow-up on any positive homes
- Sept 2009 plan. A rental property will have to provide incoming tenants a clearance report that the home is free of lead contaminants. Phase 1 will focus on pregnant women and child under 6 years of age. If currently in a unit then you can request a clearance from the owner.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Policy requirement all labs must report Lead testing to DOH			X	
2. Perinatal and Inant Health Bureau refers pregnant women for environmental evaluation for dust and lead	X			
3. Stimulus funds will support weatherization and energy – replacement of doors and windows for meet eligibility to decrease lead dust	X			
4. Lead Mobile Van - community visits to evaluate for lead	X			
5. DC passed first comprehensive legislation to mitigate lead problems, including requirement that landlords and owners must			X	

provide documentation of a lead free home.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) DDOE Lead Program has flexibility to follow up and send in inspector to look for lead hazard. The draft notice of violation and lead poison hazard is sent to DDOE and the follow-up is conducted. A report is then sent to DCRA and the landlord or owner is notified. DCRA followed up with compliance.

2) DOH Bureau Collaborations - the Lead Safe DC (National Nursing Centers Consortium) receives referrals and briefs the client, one on one education. Dust is evaluated and if positive they return and clean using specialized equipment

3) CFSA - refers properties that will serve a child (on an emergency basis). House must be safe from lead dust. The exception is if the child is placed with a family member.

4) AARA is funding a weatherization and energy program to replacement of doors and windows to decrease lead dust.

5) School Nurses -- submit health form if the lead test question is blank.

6) Continued Lead Mobile Van in the Asian and other underserved communities

c. Plan for the Coming Year

1) Continue follow-ups for lead violation referrals

2) Continue DOH Bureau Collaborations - the Lead Safe DC (National Nursing Centers Consortium) receives referrals and brief the client. Continue dust evaluation and if positive they return and clean using specialized equipment

3) Continue CFSA collaboration to evaluate any home for placed children

4) Distribution funding for weatherization and energy program to replace doors and windows to decrease lead dust.

5) Conduct follow-up from school health form if the lead test question is blank.

6) Continue Lead Mobile Van in underserved communities

7) Title V will actively participate in planning Lead Poisoning Prevention Week Activities Oct 24-30. 2010

8) Title V will help promote the Lead and Healthy Housing educational curriculum

State Performance Measure 4: *Prevalence of tobacco use among pregnant women*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7
Annual Indicator	4.3	3.7	3.5	4.4	4.4
Numerator	340	315	306	406	406
Denominator	7940	8522	8869	9135	9135
Data Source				2008 DC Birth File (Vital Statistics)	2008 DC Birth File
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.5	2.5	2.5	2	

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Notes - 2008
Numerator: Number of women who self-reported tobacco use during the pregnancy
Denominator: Number of women who answered this item on the DC birth certificate about tobacco use
Data source: The District of Columbia State Center for Health Statistics 2008 Birth file.

The percent of women who self-reported tobacco use while pregnant increased from 3.5 percent in 2007 to 4.4 percent in 2008 and represents a 28.8 percent increase. The Annual Performance Objective for this measure is 1.7 percent.

Note: The change in the 2013 performance objective reduction from 2.5 to 2.0 the continuing trend is that less women are smoking during their pregnancy. Efforts are also underway within DOH programs such as Healthy Start and community based organizations to encourage pregnant/parenting mothers to cease and quit smoking.

Notes - 2007
The prevalence of tobacco use among pregnant women decreased from 3.7 percent in 2006 to 3.4 percent in 2007, a decrease of 5.4 percent.

Source: District of Columbia State Center for Health Statistics 2007 Birth file.

Numerator: The number of women who self reported smoking during pregnancy.

Demominator: Out of the 8,870 live births, only 8869 women answered the question about smoking during their pregnancy for the birth certificate.

a. Last Year's Accomplishments
1. Continued over sight of the Healthy Start case management program, which includes education of pregnant and new moms in the health hazards related to tobacco use.
2. Continued social marketing campaign "I am a healthy DC Mom", which also instructs women in health hazards of tobacco use.
3. Participates in UMC-Breathe-DC collaborative anti-smoking collaborative.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prenatal case management services educate pregnant women on hazards of smoking	X			
2. New 2009 DC Birth certificate captures information on alcohol and smoking use		X	X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. CHA staff continues to collaborate with DHCF.

2 The Perinatal and Infant Health Bureaus continued to work with sister Bureaus to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge with the participating managed care organizations (MCO)

3 The CASH Bureau continues to provide comprehensive age appropriate health care and health education to students in a school setting; continue oversight of the school nurse program including identification of additional health education programs that will promote healthy life styles., including the effects of smoking during pregnancy and early childhood.

4 Collect data from birth certificate asking new moms about smoking habits during pregnancy. It will be self reported data.

c. Plan for the Coming Year

1 Continue smoking cessation education through Healthy Start and Family Support Workers programs

2 Continue media campaign, "I am a healthy DC Mom".

3 Continue oversight and promote expansion of Health and Sexuality Education programs in DCPS and Charter Schools.

4 Collaborate with DCPS and community based clinics to assist in the implementation of new school based health centers and collect data on teen smoking and smoking while pregnant..

State Performance Measure 6: *Percent of resident women who give birth with no prenatal care or entry into prenatal care in 3rd trimester*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	5.4	5.3	5	5	5
Annual Indicator	5.6	6.4	6.4	5.8	5.8
Numerator	392	471	494	478	478
Denominator	7025	7339	7731	8172	8172
Data Source				2008 DC Birth File (Vital Statistics)	2008 DC Birth File

Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	5	5	5	

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Notes - 2008
Numerator: Number of infants born to women with no prenatal care or entry into prenatal care in the third trimester.
Denominator: Number of infants born to women where entry into when prenatal care began was recorded (does not include 963 missing cases for which prenatal care was not reported).
Data source: The District of Columbia State Center for Health Statistics 2008 Birth file.

Infants born to women receiving no prenatal care or whose entry into prenatal care began in the third trimester decreased from 6.4 percent in 2007 to 5.8 percent in 2008, an overall decrease of 8.5%. However, this does not meet the Annual Performance Measure of 5 percent of resident women giving birth with no/3rd trimester entry into prenatal care.
.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File. The numerator reflects the number of District women who self reported recieving prenatal care (PNC) in the third trimester or no PNC during their pregnancy.

The percent of resident women who give birth with no prenatal care or prenatal care in the third trimester showed no change, at 6.4 percent in 2006 and 2007.

Note out of 8,870 live births, the denominator reflects the number of women (n=7728) that reported beginning prenatal care in the 3rd trimester or no prenatal care at all.

a. Last Year's Accomplishments
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Numerator: Number of infants born to women with no prenatal care or entry into prenatal care in the third trimester.
Denominator: Number of infants born to women where entry into when prenatal care began was recorded (does not include 963 missing cases for which prenatal care was not reported).
Data source: The District of Columbia State Center for Health Statistics 2008 Birth File.

Infants born to women receiving no prenatal care or whose entry into prenatal care began in the third trimester decreased from 6.4 percent in 2007 to 5.8 percent in 2008, an overall decrease of 8.5%. However, this does not meet the Annual Performance Measure of 5 percent of resident women giving birth with no 3rd trimester entry into prenatal care
1 CHA continues its partnerships within Bureaus and other DOH agencies to ensure that screening and identification of at-risk families is expanded to increase enrollment in prenatal care and home visitation programs. Specifically, Healthy Start's nurse case managers and family support workers will link high-risk women to needed care provided by sister agencies, including tobacco cessation, substance abuse treatment, HIV screening and care, and other services. Coordination with WIC services, continued collaboration with DC Jails and shelter
2 Continue oversight of school nurse program to identify and refer pregnant teens that are either in or out of school.

3 Continued oversight of the Healthy Start sub grants for the home visits and impact of the DOH home visitation program for pregnancy and postpartum pregnant women and their children in wards that are considered high risk areas, Ward 4, 5, 6, 7, 8. These home visitation programs promote healthier physical and social environment in the home and link families to needed care.
4 Continues the family support worker program is to increase the capacity and impact of the DOH home visitation program for pregnancy and postpartum pregnant women and their children.
5 Continued the Data Integration Project to link Kids Indirect application
6 Continued the MOM mobile unit that provides prenatal services and linkages to prenatal care and access to services and entitlements.
7 Continued to provide transportation to services for uninsured pregnant women
8 Continued to coordinate outreach and collaborated with helthcare finance managed care contracts
9 Continued the Perinatal and Interconceptual Advisory Group and established its permanency to support the efforts of the PIHB.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Case management services	X	X		
2. Collaboration with WIC in 14 IMA facilities	X			
3. Family support workers	X			
4. Collaboration with DC Jails and shelters			X	X
5. Collaboration with school nurse program to support pregnant teens	X		X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1. Oversight of the Healthy Start Program and Family support Worker program
2. Oversight of the Infant Mortality Action Plan.
3. Data Integration Project to link Kids Indirect application
4. Continue MOM mobile unit to provide prenatal services and linkages to care
5. Continue to provide transportation to services for uninsured pregnant women
6. Coordinate outreach with DHCF managed care case management staff
7. Continue to support and participate in Perinatal and Interconceptual Advisory Group.
8. Continue to monitor the impact of the public media campaign

c. Plan for the Coming Year
1 Continue oversight of the Healthy Start Program as well as the review and update the Infant Mortality Action Plan.
2 Continue to implement and evaluate strategies for improvement in perinatal and infant care over the course of the next year.
3 Continue Data Integration Project to link Kids Indirect application
4 Evaluate effectiveness of MOM mobile unit to provide prenatal services and linkages to care
5 Continue to provide transportation to services for uninsured pregnant women
6 Continue to coordinate outreach with DHCF 's managed care case managers.

7 Continue to support and participate in the Perinatal and Interconceptual Advisory Group including sub group activities
8 Expand and monitor the impact of the public media campaign to include "I am a healthy DC baby."

State Performance Measure 7: *Incidence of repeat births for teens less than 19 years of age*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	19.3	19	18.5	18.5	18.5
Annual Indicator	14.0	12.1	12.5	12.0	12.0
Numerator	81	84	89	89	89
Denominator	580	693	713	742	742
Data Source				2008 DC Birth File (Vital Statistics)	2002 DC Birth File
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	18.5	18	18	17.5	

Notes - 2009
Numerator: Number of resident live births for teens less than 19 years of age that was a repeat birth
Denominator: Number of resident live births for teens less than 19 years of age
Data source: The District of Columbia State Center for Health Statistics 2008 Birth file.

Notes - 2008
Numerator: Number of resident live births for teens less than 19 years of age that was a repeat birth
Denominator: Number of resident live births for teens less than 19 years of age
Data source: The District of Columbia State Center for Health Statistics 2008 Birth file.

Repeat births among teens less than 19 years of age decreased from 12.5 percent in 2007 to 12.0 percent in 2008, representing an overall decrease of 3.9%. This figure is lower than the Annual Performance Objective of 18.5 percent and reflects the District's continuing efforts to reduce the incidence of repeat births among teens.

Notes - 2007
The incidence of repeat teen births for teens less than 19 years of age increased from 12.1 percent in 2006 to 12.5 percent in 2007, an increase of 3.3 percent.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

a. Last Year's Accomplishments
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Numerator: Number of resident live births for teens less than 19 years of age that was a repeat birth
Denominator: Number of resident live births for teens less than 19 years of age

Data source: The District of Columbia State Center for Health Statistics 2008 Birth File.

Repeat births among teens less than 19 years of age decreased from 12.5 percent in 2007 to 12.0 percent in 2008, representing an overall decrease of 3.9%. This figure is lower than the Annual Performance Objective of 18.5 percent and reflects the District's continuing efforts to reduce the incidence of repeat births among teens

a. Last Year's Accomplishments
1 CHA CASH Bureau continued its oversight and collaboration with school nurses to provide health education services in the DC Public Schools and Charter Schools.
2 PIHB collaborative activities: 1) early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance utilizing Healthy Start case managers and family support workers; 2) Expanded well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge; 3) conducted routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant; 4) Enhanced linkage to APRA and other community based substance abuse education and treatment services; 5) Enhanced community-based screening and prevention services for at risk families and youth served by child protective service agency; 6) Facilitated outreach and linkages to care for homeless pregnant women and living in shelters; 7) Improved screening practices for all women and youth at risk for mental illness; and 8) Continued to work with the Department of Corrections to provide adequate prenatal care for pregnant inmates during incarceration.
3 Continued the 1-800-MOM-BABY HEALTHLINE through the 311 number to provide information about pregnancies.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Subgrantees to offer "Girl Talk2" and "Healthy Generations" programs for second pregnancy prevention programs	X		X	
2. Carerra Model to promote self efficacy in young girls	X		X	
3. MOM unit to provide prenatal services and linkages to services	X			
4. Collaboration with HASTA and APRA for bidirectional services		X	X	
5. Child and Family Services Administration collaboration			X	X
6. Perinatal Advisory Board identifying strategies to address repeat births among teens			X	X
7.				
8.				
9.				
10.				

b. Current Activities
1. District is establishing and funding three new school based health centers, which will include providing, comprehensive health services, and pregnancy prevention programs.
2. CASH Bureau continues its oversight, monitoring compliance and collaboration with school nurses to provide health education services in the DC Public Schools and selected Charter Schools.
3. The Perinatal and Infant Health Bureau activities include 1) increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance; 2) Increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge; 3) Implement routine prenatal HIV testing and treatment that prevents

perinatal HIV transmission to the infant; 4) Enhance linkage to substance abuse education and treatment services; 5) Enhance community-based screening and prevention services for at risk families and youth served by child protective service agency 6) Facilitate outreach and linkages to care for homeless pregnant women; 7) Improve screening practices for all women and youth at risk for mental illness; and 8) Provide adequate prenatal care for pregnant inmates during incarceration.9) Continued social marketing campaign "I am a Healthy DC Mom".
4. Provided oversight of the sub grantee implementing the Carrera Model.

c. Plan for the Coming Year

1. Continue Health and Sexuality Education Programs at various DCPS and a few Charter Schools as well as the Woodson Adolescent Wellness Center continue to provide health and sexuality education, comprehensive health services, and pregnancy prevention programs.
2. Continue CHA CASH Bureau oversight, monitoring compliance and collaboration with school nurses to provide health education services in the DC Public Schools and selected Charter Schools.
3. Continue the Perinatal and Infant Health Bureau activities include 1) increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance; 2) Increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge; 3) Implement routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant; 4) Enhance linkage to substance abuse education and treatment services; 5) Enhance community-based screening and prevention services for at risk families and youth served by child protective service agency; 6) Facilitate outreach and linkages to care for homeless pregnant women; 7) Improve screening practices for all women and youth at risk for mental illness; and 8) Provide adequate prenatal care for pregnant inmates during incarceration. 9) Expand social marketing campaign to "I am a healthy DC baby."
4. Continue to support a sub grant to support the Carrera Model.

State Performance Measure 8: *Percentage of high school students who were in a physical fight one or more times during the past 12 months*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		33	30	28	26
Annual Indicator	36.3	36.3	43	43	43
Numerator					
Denominator					
Data Source				2007 YRBSS	2007 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	25	25	25	25	

Notes - 2009

This District of Columbia's 2009 YRBS data were not weighted because the overall response rate was below 60%. The data can only be used to describe the students who took the survey and not all the high school or middle school students in DC.

Source: 2007 YRBSS

Retrieved on 06/23/2010 from
http://apps.nccd.cdc.gov/yrbss/CompTableoneLoc.asp?X=1&Loc=DC&Year1=2007&Year2=2005

Notes - 2008
Source: 2007 YRBSS

Retrieved on April 3, 2009 from
http://apps.nccd.cdc.gov/yrbss/CompTableoneLoc.asp?X=1&Loc=DC&Year1=2007&Year2=2005

Notes - 2007
Source:
http://apps.nccd.cdc.gov/yrbss/QuestYearTable.asp?ByVar=CI&cat=1&quest=Q20&loc=DC&year=2007 95% confidence interval.

Technical Assistance was requested to address Violence Prevention in DC.

Note; The YRBS is conducted in odd years.

a. Last Year's Accomplishments

Retrieved on April 3, 2009 from
http://apps.nccd.cdc.gov/yrbss/CompTableoneLoc.asp?X=1&Loc=DC&Year1=2007&Year2=2005

Technical Assistance was requested to address Violence Prevention in DC.

a. Last Year's Accomplishments

1) Implemented a school health plan that includes school violence prevention programs at selected schools with a high incidence of youth violence in collaboration with DCPS.

2) Collaborated with DC Public Schools nurse program to monitor the screening and referral systems for mental health and other issues that may lead to school violence. Full service middle school wellness teams detect behavioral problems and address them before they become clinically significant.

3) Continued the Rape Prevention and Education (RPE) Program with other CHA components and several other DC DOH administrations to provide sexual violence and dating violence prevention in DC Public Schools.

4) Continued to analyze the appropriate policy and programs that address rate of deaths due to violence and injury.

5) Continued to evaluate the best practices to mitigate youth violence and injury among District middle and high school students.

6) Continued to analyze the appropriate policy and programs that address rate of deaths due to violence and injury and develop strategies to mitigate physical fights in schools and neighborhoods.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Granted funds for violence prevention programs - included case management services	X		X	X
2. In coming year develop Youth Action Plan to address			X	X

startegies for youth violence				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Working with DC Public Schools along with other youth-related programs continued to implement a school health plan strategies that includes school violence prevention programs at selected schools with a high incidence of youth violence.

2) Collaborating with DC Public Schools nurse program to monitor the screening and referral systems for mental health and other issues that may lead to school violence. Full service middle school wellness teams detect behavioral problems and address them before they become clinically significant.

3) Continuing the Rape Prevention and Education (RPE) Program with other CHA components and several other DC DOH administrations to provide sexual violence and dating violence prevention in DC Public Schools.

4) Analyzing the appropriate policy and programs that address rate of deaths due to violence and injury.

5) Evaluating in collaboration with community based organizations and youth justice system the best practices to mitigate youth violence and injury among District middle and high school students.

6) Continuing to analyze the appropriate policy and programs that address rate of deaths due to violence and injury and develop strategies to mitigate physical fights in schools and neighborhoods.

c. Plan for the Coming Year

1) Continue work with DC Public and Charter Schools along with other youth-related programs continued to implement a school health plan strategies that includes school violence prevention programs at selected schools with a high incidence of youth violence.

2) Continue to collaborate with DC Public Schools nurse program and DMH to monitor the screening and referral systems for mental health and other issues that may lead to school violence. Full service middle school wellness teams detect behavioral problems and address them before they become clinically significant.

3) Continue the Rape Prevention and Education (RPE) Program with other CHA components and several other DC DOH administrations to provide sexual violence and dating violence prevention in DC Public Schools.

4) Develop a Youth Action Plan and identify relevant policy and programs that address rate of deaths due to violence and injury and develop strategies to mitigate these events.

5) Continue subgrant to mitigate youth violence and injury among District middle and high

school students.

State Performance Measure 9: *Percent of preterm births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		12	11.5	11	10.5
Annual Indicator	12.5	13.4	12.2	12.2	12.2
Numerator	989	1135	1076	1114	1114
Denominator	7897	8464	8818	9097	9097
Data Source				2008 DC Birth File (Vital Statistics)	2008 DC Birth File
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Notes - 2008
Numerator: Number of preterm births < 37 weeks gestation
Denominator: Number of live births where gestation was recorded (n=9097); excludes missing data (n=38)
Data source: The District of Columbia State Center for Health Statistics 2008 Birth file.

Infants born preterm, <37 weeks gestation, remained the same in 2008 as in 2007 (12.2%) and does not meet the Annual Performance Objective of 11% established for this measure.

Notes - 2007
The percent of pre term births decreased from 13.4 percent in 2006 to 12.2 percent in 2006, a decrease of 8.9 percent.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The numerator (n=1076) is the number of births < 37 weeks gestation.

The denominator (n=8818) of live birth excludes the missing data n=52.

a. Last Year's Accomplishments
The percent of pre term births decreased from 13.4 percent in 2006 to 12.2 percent in 2006, a decrease of 8.9 percent.

1) DOH continues a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality. CHA will be collaborating with a number of programs to assess the various data that are captured for inclusion in trend analysis.

In addition, CHA will be developing a database on infant birth, morbidity and mortality statistics for the State to assist programs with planning and services.

2) Increase coordination with DC Jails and shelters expand a comprehensive, citywide approach to reducing infant mortality.

3) Convened a Healthy Start Conference to strengthen its partnership with healthcare providers, community-based organizations, and patient advocacy groups to identify opportunities for collaboration and mutual support in the effort to prevent mortality, lifelong disabling conditions, and other threats to infant health.

4) Expanded the Family Support Worker Program to improve discharge planning and linkage to appropriate medical and social services for women admitted to birthing hospitals with inadequate prenatal care and at risk for domestic violence, substance abuse or other factors that negatively affect infant development;

5) Developed a public information campaign, "I am a Healthy DC Mom" which was vetted in the community

6) Continues the advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities. Membership includes DOH and National Institute of Child Health and Human Development (NICHD), health care providers, managed care companies, and community-based organizations; and 4) Commission a comprehensive study of factors associated with infant death and developmental disability for Medicaid beneficiaries in the District of Columbia and identify novel population-based preventive activities

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Healthy Start Program and Home Visitation Program	X		X	
2. Family Support Worker Program	X			
3. Collaborations with various DC agencies: DHCF, DC Jail, shelters, CFSA			X	X
4. School nurse program to support pregnant teens	X		X	
5. Public Information Campaign - "I am a Healthy DC Mom" and new campaign "I am a Healthy DC Baby"		X	X	X
6. Implement 3 new High School school based health clinics	X		X	X
7.				
8.				
9.				
10.				

b. Current Activities

1. Epidemiology continues a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality.

2) Continues coordination with DC Jails and shelters to identify pregnant women and refer to services and entitlements in efforts to reduce infant mortality.

3) Continue the Family Support Worker Program to improve discharge planning and linkage to appropriate medical and social services for women admitted to birthing hospitals with inadequate

prenatal care and at risk for domestic violence, substance abuse or other factors that negatively affect infant development;

4) Launch and continue the public information campaign " I am a Healthy Mom"

5) Continues to support and participate in the advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities

c. Plan for the Coming Year

1. Develop a Request for Proposal to seek a vendor to conduct the PRAMS Survey for the Maternal Child Program. and individual health care interventions that will reduce infant mortality.
2. Develop an evaluation of the Healthy Start program and at the same time develop program outcomes.
3. Continue trend analysis of infant mortality
4. Continue the public information campaign "I am a Healthy DC Healthy Mom" and evaluate short term success

E. Health Status Indicators

Introduction

The District's estimated population in 2007 of 588,292 showed a 2.8% increase. In 2006, the population distribution was 55.5% African American, 34.5% Caucasian, 8.2% Hispanic, 5.1% includes Native Americans, Alaskans, Hawaiians, and Pacific Islanders, 3.4% Asian, and 1.5% mixed (two or more races). The 2006 American Community Survey found that only 40% of current D.C. residents were born in the District, 16% below the national average. District residents live in one of the eight Wards.

The District continues its efforts: 1) The Safe Passages Information System (SPIS). 2) DC Vital Records reporting of data collected at the time of delivery including alcohol and smoking use during pregnancy. The DC Primary Care Association is continuing the development and implementation of the DC Regional Health Information Organization (DC RHIO). 3. Expanding and supporting Medical Homes Project. 4) Support the project, Destination Known: Making Health Care Transition Happen for YSHCN in DC who are transitioning from pediatric care into adult care. This initiative will identify best practice models for transition case management.

DOH released a RFA for the start-up and operations of three school health centers in DC at Anacostia, Ballou, and Coolidge High Schools. Three sub grantees have each been awarded one grant to operate one of the three high school clinics. The overall goal is to help address the primary and urgent care needs of students in the schools in underserved areas.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.5	9.0	11.1	10.5	10.5
Numerator	674	769	989	960	960
Denominator	7940	8522	8870	9135	9135
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Notes - 2008
The percent of live births weighing less than 2,500 grams decreased from 11.1 percent on 2007 to 10.5 percent in 2008, a decrease of 5.4 percent.

Numerator: Number of infants weighing less than 2,500 grams.
Denominator: Number of District resident infants born in 2008
Data source: The District of Columbia State Center for Health Statistics 2008 Birth File.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The denominator: Out of the 8870 live births, only 8862 had birthweights recorded, and 8 infants w/o recorded birthweights. Those eight were coded as 9999 for missing.

Narrative:
2009 data will not be reported until 2011. The Perinatal and Infant Health Bureau continues its Healthy Start case management and home visitation programs as well a Family Support Worker program to conduct outreach efforts to pregnant women. Outreach efforts include use of MOM van; staff co-located in WIC centers; and collaboration with District agencies such as DC Jails, shelters and Child and Family Services Administrators. The new social marketing campaign "I am a health DC Baby." will be developed a launched this grant year and focuses on education of parents in ensuring the healthy growth and development of District babies.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.0	7.7	9.3	8.8	8.8
Numerator	535	635	796	772	772
Denominator	7636	8198	8543	8788	8788
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Notes - 2008
The percent of singleton births weighing less than 2, 500 grams has fallen from 9.3 percent in 2007 to 8.8 percent in 2008, decrease of 5.3 percent.

Numerator: Number of singleton infants weighing less than 2,500 grams.

Denominator: Number of singleton births

Data source: The District of Columbia State Center for Health Statistics 2008 Birth File.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The numerator reflects that n=796 live singleton births weighing <2,500 grams.

The denominator (n=8543) accounts for the number of live singleton births.

Narrative:
/2011/ Data is reported every two years, therefore 2009 data will not be available until 2011. The Perinatal and Infant Health Bureau continues its Healthy Start case management and home visitation programs as well a Family Support Worker program to conduct outreach efforts to pregnant women. Outreach efforts include use of MOM van; staff co-located in WIC centers; and collaboration with District agencies such as DC Jails, shelters and Child and Family Services Administrators.

Other efforts include: 1) the development and launch of the public information campaign DC Healthy Mom focused on keeping babies safe, including parenting, wellness and screening requirements. 2) Collaboration with the newly named Department of Health Care Financing (DHCF) to promote well child visits. 3) promotion and implementation of "Girl Talk" and "Healthy Generations" as well as Carerra Model to address and mitigate teen pregnancies, including rapid second pregnancies in teens. The new social marketing campaign "I am a health DC Baby." will be developed a launched this grant year and focuses on education of parents in ensuring the healthy growth and development of District babies.//2011//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.7	2.5	2.9	2.6	2.6
Numerator	214	217	258	234	234
Denominator	7940	8522	8870	9135	9135
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Notes - 2008
Analysis: The percent of live births weighing less than 1,500 grams decreased by 13.7 percent from 2.9 percent in 2007 to 2.5 percent in 2008.

Numerator: Number of live births weighing less than 1,500 grams (very low birth weight).

Denominator: Number of births

Data source: The District of Columbia State Center for Health Statistics 2008 Birth File.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The denominator: Out of the 8870 live births, only 8862 had birthweights recorded, leave 8 infants w/o recorded birthweights. Those eight were coded as 9999 for missing.

Narrative:
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Analysis: The percent of singleton births weighing less than 1,500 grams has fallen from 9.3 percent in 2007 to 8.8 percent in 2008, decrease of 5.3 percent.

Numerator: Number of live births weighing less than 1,500 grams (very low birth weight).

Denominator: Number of births

Data Source: District of Columbia State Center for Health Statistics 2008 Birth File.

Narrative:
/2011/ The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. The Perinatal and Infant Health Bureau continues its Healthy Start case management and home visitation programs as well a Family Support Worker program to conduct outreach efforts to pregnant women. Outreach efforts include use of MOM van; staff co-located in WIC centers; and collaboration with District agencies such as DC Jails, shelters and Child and Family Services Administrators.

Other efforts include:
1. The development and launch of the public information campaign DC Healthy Mom focused on keeping babies safe, including parenting, wellness and screening requirements.
2. Collaboration with the Department of Health Care Financing (DHCF) to promote well child visits with managed care case managers.
3. Promotion and implementation of "Girl Talk" and "Healthy Generations" as well as Carerra Model to address and mitigate teen pregnancies, including rapid second pregnancies in teens.
4. Continued its social marketing campaign "I am a healthy DC Mom" and will expand to include "I am a Healthy DC baby." //2011//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Indicator	2.1	2.0	2.3	2.1	2.1
Numerator	160	164	198	187	187
Denominator	7636	8198	8537	8786	8786
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. Data for 2008 is reported here.

Notes - 2008
The percent of live births singleton births weighing less than 1,500 grams slightly decreased by 0.86 percent from 2.3 in 2007 to 2.1 in 2008.

Numerator: Number of live births weighing less than 1,500 grams (very low birth weight).

Denominator: Number of singletonf births

Data source: The District of Columbia State Center for Health Statistics 2008 Birth File.
.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The denominator (n=8537) accounts for the number of live singleton births. There were 2 births coded as 9999 were "missing" birthweights for 2 singelton deliveries.

Narrative:
/2011/ The District of Columbia has a 2-year delay for reporting birth data. Data for 2009 will be reported in 2011. The Perinatal and Infant Health Bureau continues its Healthy Start case management and home visitation programs as well a Family Support Worker program to conduct outreach efforts to pregnant women. Outreach efforts include use of MOM van; staff co-located in WIC centers; and collaboration with District agencies such as DC Jails, shelters and Child and Family Services Administrators.

Other efforts include:
1. The development and launch of the public information campaign DC Healthy Mom focused on keeping babies safe, including parenting, wellness and screening requirements.
2. Collaboration with the Department of Health Care Financing (DHCF) to promote well child visits with managed care case managers.
3. Promotion and implementation of "Girl Talk" and "Healthy Generations" as well as Carerra Model to address and mitigate teen pregnancies, including rapid second pregnancies in teens.
4. Continued its social marketing campaign "I am a healthy DC Mom" and will expand to include "I am a Healthy DC baby." //2011//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	6.2	6.3	7.4	7.6	7.6
Numerator	6	6	7	7	7
Denominator	96217	95176	93980	92412	92412
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	Yes
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data will be updated when the 2009 birth file is available.

Source: Numerator: The District of Columbia, State Center For Health Statistics 2008 Death File.

Denominator: United States Census Bureau. The 2008 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2008
Source: Numerator: The District of Columbia, State Center For Health Statistics 2008 Death File.

Denominator: United States Census Bureau. The 2008 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2007
Source: Numerator: The District of Columbia, State Center For Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Narrative:
/2011/ District agencies, in 2009 applied for more than $5 Million in AARA or Stimulus Grants for Crime Control, Youth Violence Prevention, and Victim Assistance. The Englewood and Brookland Collaborative with it sub grantees Peaceaholics and Sasha Brooks were awarded a grant to provide outreach and case management services to at-risk youths involved in crews and gangs and at risk for violent activities. The grant was transferred to DOH and CHA provided additional funds to support the grant. The District recognizes the need to develop strategies for outreach and reception by youth to participate in activities that address the issues that will enable them to avoid or reject violent and crew/gang behavior. This grant focused on 150 youth ages 14-24 residing in the Edgewood and Brookland areas. The challenges that the grantee identified in the implementation of the project included: youth often ineligible to meet education requirements for a GED; youth refusal to return to school; little or no parental or family support; and a limited number of staff with street credit to approach and interact with youth. CASH staff is working close with Collaborative to develop strategies to address the challenges and barriers to successfully achieve the objectives of the grant.

CHA will develop a Youth Action Plan in the coming grant year. Strategies to address youth at risk for violence, unintended injuries and self inflicted injuries will be included in the Plan. CHA will

invite community leaders, advocates, youth peers; and agencies providing services to participate in the development of the Plan. //2011//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	4.2	3.2	1.1	1.1
Numerator	0	4	3	1	1
Denominator	96217	95176	93980	92412	92412
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The District of Columbia has a 2-year delay for reporting death data. Currently, the number of deaths in 2009 among children ages 1-14 due to motor vehicle accidents is used to report information for 2008. The 2009 data will be available in 2011, and this measure will be updated.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death File.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Notes:

Deaths due to motor vehicle crashes among children aged 1-14 (n = 1) continues to decrease in the District of Columbia. The rate of 1.1 per 100,000 in 2008 is lower than the 2007 rate which was 3 per 100,000 for this measure.

Notes - 2008
The District of Columbia has a 2-year delay for reporting death data. Currently, the number of deaths in 2009 among children ages 1-14 due to motor vehicle accidents is used to report information for 2008. The 2009 data will be available in 2011, and this measure will be updated.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death File.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Notes:

Deaths due to motor vehicle crashes among children aged 1-14 (n = 1) continues to decrease in the District of Columbia. The rate of 1.1 per 100,000 in 2008 is lower than the 2007 rate which

was 3 per 100,000 for this measure.

*Denominator does not include 2008 births.

Notes - 2007
Source: Numerator: The District of Columbia, State Center For Health Statistics 2007 Death File. The numerator is correct as there were only 3 deaths attributed to motor vehicle crashes.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html
.

Narrative:
The District has a 2-year delay in reporting death data. Currently the number of deaths in 2008 among infants and children aged 1-14 caused by motor vehicle crashes is used to report information for 2009. The 2009 data will be available and reported in 2011.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death File.
Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at:
http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Narrative:
/2011/ Although the number of deaths due to motor vehicle accidents are low in children aged 14 and younger, CHA expects to develop a Youth Action Plan in this grant year and analyze data requirements and identify policies, activities, etc that impact children aged 14 years and younger with injuries due to motor vehicles crashes. //2011//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.2	2.2	4.3	2.1	2.1
Numerator	2	2	4	2	2
Denominator	90414	92860	93448	94838	94838
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The District of Columbia has a 2-year delay for reporting death data. Currently, the number of deaths in 2009 among children ages 15-24 due to motor vehicle accidents is used to report information for 2008. The 2009 data will be available in 2011, and this measure will be updated.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death File.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Notes:

Deaths due to motor vehicle crashes among youths aged 15-24 (n = 2) continues to decrease in the District of Columbia. The rate of 2 per 100,000 in 2008 is lower than the 2007 rate which was 4 per 100,000 for this measure.

Notes - 2008
The District of Columbia has a 2-year delay for reporting death data. Currently, the number of deaths in 2009 among children ages 15-24 due to motor vehicle accidents is used to report information for 2008. The 2009 data will be available in 2011, and this measure will be updated.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death File.

Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Notes:

Deaths due to motor vehicle crashes among youths aged 15-24 (n = 2) continues to decrease in the District of Columbia. The rate of 2 per 100,000 in 2008 is lower than the 2007 rate which was 4 per 100,000 for this measure.

Notes - 2007
Source: Numerator: The District of Columbia, State Center for Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Narrative:
The District has a 2-year delay in reporting death data. Currently the number of deaths in 2008 among youth aged 15-24 caused by motor vehicle crashes is used to report information for 2009. The 2009 data will be available and reported in 2011.

Source Numerator: The District of Columbia State Center for Health Statistics 2008 Death File.
Source Denominator: United States Census Bureau 2008 American Fact Finder Population Estimates for the District of Columbia available at: http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=295373522343 .

Narrative:
/2011/ Although the number of deaths due to motor vehicle accidents are low in youth aged 15-24, CHA expects to develop a Youth Action Plan in this grant year and analyze data requirements and identify policies, activities, etc that impact children aged 15 through 24 with injuries due to motor vehicles crashes. //2011//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator					
Numerator			0	0	0
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The District does not have an injury surveillance system. No estimates are available for 2009.

Notes - 2008
The District does not have an injury surveillance system. No estimates are available for 2008.

Notes - 2007
The District does not have an injury surveillance system. No estimates are available for 2007.

Narrative:
/2011/ No data reported as the District does not have an injury surveillance system in place. CHA expects to develop a Youth Action Plan in this grant year and analyze data requirements and identify policies, activities, etc that impact children aged 14 years and younger with non fatal injuries among children aged 14 years and younger.//2011//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator					
Numerator			0	0	0
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The District does not have an injury surveillance system. No estimates are available for 2009.

Notes - 2008
The District does not have an injury surveillance system. No estimates are available for 2008.

Notes - 2007
The District does not have an injury surveillance system. No estimates are available for 2007.

Narrative:
2011/ No data reported as the District does not have an injury surveillance system in place. CHA expects to develop a Youth Action Plan in this grant year and analyze data requirements and identify policies, activities, etc that impact children aged 14 years and younger with nonfatal injuries due to motor vehicles crashes. //2011//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator					
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	

Notes - 2009
The District does not have an injury surveillance system. No estimates are available for 2009.

Notes - 2008
The District does not have an injury surveillance system. No estimates are available for 2008.

Notes - 2007
The District does not have an injury surveillance system. No estimates are available for 2007.

Narrative:
/2011/ No data reported as the District does not have an injury surveillance system in place. CHA expects to develop a Youth Action Plan in this grant year and analyze data requirements and identify policies, activities, etc that impact children aged 14 years and younger with injuries due to motor vehicles crashes. //2011//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	90.4	74.8	77.6	89.0	76.2
Numerator	1170	1006	1639	1895	1796
Denominator	12937	13448	21115	21290	23571
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator: 2009 STD MIS final data.
Denominator: U.S. Census Bureau, 2008 American Community SurveyDistrict of Columbia B01001 Sex by Age total population

Notes - 2008
Source: Numerator: 2008 STD MIS data.

Denominator: Table 2: Annual Estimates of the Resident Population by Sex and Age for District of Columbia: April 1, 2000 to July 1, 2008 (SC-EST2008-02-11)

Notes - 2007
Numerator: Source 2007 District of Columbia STD disease report., generated by STD*MIS database.

Denominator: US Census 2005 population estimates.

Narrative:
/2011/ The rate of women aged 15 through 19 years with a reported case of Chlamydia increased/decreased from a rate of 89 per 1,000 women in 2007 to a rate of 76.2 per 1,000 in 2008, a decrease of from 2008.
The Department of Health as well as HASTA has continued to aggressively encouraged teens to participate in testing. In addition, CHA offers health and sexuality education, promoting the need for screening and impact of STDs at school based clinics and during health and sexuality education classes. The implementation of three new HS health clinics will continue opportunities for testing and reporting. //2011//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	13.6	13.6	17.3	18.2	17.4
Numerator	1674	1674	2136	2319	2179
Denominator	123339	123339	123339	127546	125495
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator: 2009 STD MIS final data.
Denominator: U.S. Census Bureau, 2008 American Community SurveyDistrict of Columbia B01001 Sex by Age total population

Notes - 2008
Source:
Denominator: 2008 STD MIS data.

Numerator; Table 2: Annual Estimates of the Resident Population by Sex and Age for District of Columbia: April 1, 2000 to July 1, 2008 (SC-EST2008-02-11)

Narrative:
2011/ The rate of women aged 20 through 44 years with a reported case of Chlamydia increased/decreased from a rate of 81.2 per 1,000 women in 2007 to a rate of 17.3 per 1,000 in 2008, a decrease from 2008. The Department of Health as well as HASTA has continued to aggressively encouraged women to participate in testing through WIC outreach and the PIHB social marketing campaign "I am a Healthy DC Mom." //2011//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	9135	1947	4585	1	55	71	0	2476
Children 1 through 4	36015	13098	19850	0	1087	0	713	1267
Children 5 through 9	27524	7032	17519	0	793	0	806	1374
Children 10 through 14	28873	4750	20548	0	722	0	1092	1761
Children 15 through 19	43681	13621	25343	0	1733	0	1167	1817
Children 20 through 24	51154	23272	23656	0	2141	0	991	1094
Children 0 through 24	196382	63720	111501	1	6531	71	4769	9789

Notes - 2011
Source: The District of Columbia State Center for Health Statistics 2008 Birth File.

Source: US Census Bureau-2008 American Community Survey 1-Year Estimates for the District of Columbia.
Table: Sex by Age by Race
Link:
http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
Date Retreived: 07/05/2010

Source: US Census Bureau-2008 American Community Survey 1-Year Estimates for the District of Columbia.
Table: Sex by Age by Race
Link:

http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
Date Retreived: 07/05/2010

Source: US Census Bureau-2008 American Community Survey 1-Year Estimates for the District of Columbia.
Table: Sex by Age by Race
Link:
http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
Date Retreived: 07/05/2010

Source: US Census Bureau-2008 American Community Survey 1-Year Estimates for the District of Columbia.
Table: Sex by Age by Race
Link:
http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
Date Retreived: 07/05/2010

Source: US Census Bureau-2008 American Community Survey 1-Year Estimates for the District of Columbia.
Table: Sex by Age by Race
Link:
http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
Date Retreived: 07/05/2010

Narrative:
/2011/The District's estimated population in 2007 of 588,292 showed a 2.8% increase. In 2006, the population distribution was 55.5% African American, 34.5% Caucasian, 8.2% Hispanic, 5.1% includes Native Americans, Alaskans, Hawaiians, and Pacific Islanders, 3.4% Asian, and 1.5% mixed (two or more races). The 2006 American Community Survey found that only 40% of current D.C. residents were born in the District, 16% below the national average. //2011//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	7572	1527	36
Children 1 through 4	9644	5187	0
Children 5 through 9	5778	3115	0
Children 10 through 14	3929	2578	0
Children 15 through 19	12070	4361	0
Children 20 through 24	21618	3294	0
Children 0 through 24	60611	20062	36

Notes - 2011
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: US Census Bureau-2008 American Community Survey 1-Year Estimates for the District of Columbia.
Table: Sex by Age by Hispanic Origin
Link:
http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
Date Retreived: 07/05/2010

Source: US Census Bureau-2008 American Community Survey 1-Year Estimates for the District of Columbia.
Table: Sex by Age by Hispanic Origin
Link:
http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
Date Retreived: 07/05/2010

Source: US Census Bureau-2008 American Community Survey 1-Year Estimates for the District of Columbia.
Table: Sex by Age by Hispanic Origin
Link:
http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
Date Retreived: 07/05/2010

Source: US Census Bureau-2008 American Community Survey 1-Year Estimates for the District of Columbia.
Table: Sex by Age by Hispanic Origin
Link:
http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
Date Retreived: 07/05/2010

Source: US Census Bureau-2008 American Community Survey 1-Year Estimates for the District of Columbia.
Table: Sex by Age by Hispanic Origin
Link:
http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
Date Retreived: 07/05/2010

Narrative:
/2011/ Each of the CHA's Bureaus have developed programs and collaborative relationships with the Latino community and other sub-populations, such as Asian Pacific islanders to identify children at-risk, difficulty accessing services; and develop strategies to mitigate issues. For example, WIC programs provide food and nutrition support to more than 19000 women and children in the District, Mary's Center provides home visitation services for the new Latina moms and babies. //2011//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY	Total	White	Black or	American	Asian	Native	More than	Other and

Total live births	**All Races**		**African American**	**Indian or Native Alaskan**		**Hawaiian or Other Pacific Islander**	**one race reported**	**Unknown**
Women < 15	32	0	28	0	0	0	0	4
Women 15 through 17	389	8	305	0	1	1	0	74
Women 18 through 19	694	16	571	0	0	2	0	105
Women 20 through 34	6177	1440	3517	3	73	85	0	1059
Women 35 or older	1835	1037	615	1	18	36	0	128
Women of all ages	9127	2501	5036	4	92	124	0	1370

Notes - 2011

Narrative:
/2011// DOH has expanded programs to address teen sexual health and pregnancy. Through sub grant awards DOH supports programs such a "Girl Talk2" "Healthy Generations" and Carerra Model programs as well as staff conducting health and sexuality education programs in DC Public and Charter schools. //2011//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	27	5	0
Women 15 through 17	314	75	0
Women 18 through 19	582	112	0
Women 20 through 34	5007	1167	4
Women 35 or older	1667	168	2
Women of all ages	7597	1527	6

Notes - 2011

Narrative:
/2011/ provisional data for 2009 reports an estimated 20% decrease in births this reporting period.
CHA continues its I ama health DC Mom social marketing campaign and will expand to include "I am a healthy DC baby" this coming grant year.

Home visitation, lead case management programs and environmental assessments as well as WIC programs and services focus on wellness during pregnancy as well as for newborns. In addition, PIHB collaborates with DC Jails to ensure pregnant women access to healh care. //2011//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	147	30	97	0	0	0	3	17
Children 1 through 4	18	8	9	0	0	1	0	0
Children 5 through 9	8	1	7	0	0	0	0	0
Children 10 through 14	10	5	4	0	0	1	0	0
Children 15 through 19	42	0	42	0	0	0	0	0
Children 20 through 24	53	6	46	0	1	0	0	0
Children 0 through 24	278	50	205	0	1	2	3	17

Notes - 2011
Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Narrative:
/2011/ Statistics are from previous reporting period and therefore do not reflect changes based on program enhanced or established to address infant and children deaths. Programs, such as Healthy Start, Family Support Workers, as well as education in Sickle Cell Disease, STDS, Lead programs, metabolic screening, and other chronic diseases continue to promote wellness and treatment strategies. CHA is seeking technical assistance to evaluate deaths in children and then develop strategies to mitigate death in infants and children. //2011//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	118	10	19
Children 1 through 4	15	3	0

Children 5 through 9	7	1	0
Children 10 through 14	9	1	0
Children 15 through 19	42	0	0
Children 20 through 24	50	3	0
Children 0 through 24	241	18	19

Notes - 2011
Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Source: The District of Columbia State Center for Health Statistics 2008 Death File.

Narrative:
/2011/ Statistics are from previous reporting period and therefore do not reflect changes based on program enhanced or established to address infant and children deaths. Programs, such as Healthy Start, Family Support Workers as well as education in Sickle Cell Disease, metabolic screening, and other chronic diseases continue to promote wellness and treatment strategies. CHA is seeking technical assistance to evaluate deaths in children and then develop strategies to mitigate death in infants and children. //2011//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	145228	40448	87845	1	4390	71	3778	8695	2008
Percent in household headed by single parent	40.0	0.0	0.0	0.0	0.0	0.0	0.0	40.0	2008
Percent in TANF (Grant) families	11.0	0.0	0.0	0.0	0.0	0.0	0.0	11.0	2009
Number enrolled in Medicaid	164900	0	0	0	0	0	0	164900	2009
Number enrolled in SCHIP	6307	0	0	0	0	0	0	6307	2009
Number	2217	0	0	0	0	0	0	2217	2009

living in foster home care									
Number enrolled in food stamp program	99203	0	0	0	0	0	0	99203	2009
Number enrolled in WIC	4949	0	0	0	0	0	0	4949	2009
Rate (per 100,000) of juvenile crime arrests	2.7	0.2	4.4	0.0	1.4	2.8	0.0	0.1	2009
Percentage of high school drop-outs (grade 9 through 12)	11.0	0.0	0.0	0.0	0.0	0.0	0.0	11.0	2009

Notes - 2011
Data Source: U.S. Census Bureau-American Community Survey 1-Year Population Estimates-2008

Table: Age by Sex
Link: http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=04000US11&-context=adp&-ds_name=ACS_2008_1YR_G00_&-tree_id=308&-_lang=en&-_caller=geoselect&-format=

Data Source: Kids Count Data Center-District of Columbia
Table Title: Children in Single Parent Families by Race
Link:
http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=DC&cat=402&group=Category&loc=10&dt=1%2c3

Data Source: This data was provided by Brian Campbell, Special Assistant in the District of Columbia Department of Health Services Income Maintainance Administration. The data was abstracted by Mr. Campbell from ACEDS (Automated Client Eligibiligy Determinatgion System).
Actual Number: The actual number of participants in 2009 was 16,110.

Data Source: The Kaiser Family Foundation's State Health Profile: District of Columbia-2008

Link: http://www.statehealthfacts.org/profileglance.jsp?rgn=10&rgn=1

Data Source: The Kaiser Family Foundation-Monthly CHIP Enrollment-District of Columbia

Link: http://www.statehealthfacts.org/profileind.jsp?ind=236&cat=4&rgn=10&cmprgn=1

Note: The data is a cross sectional monthly enrollment average.

Data Source: This data was provided by Brian Campbell, Special Assistant in the District of Columbia Department of Health Services Income Maintainance Administration. The data was abstracted by Mr. Campbell from ACEDS (Automated Client Eligibiligy Determinatgion System).
Actual Number: The actual number of participants in 2009 was 99203.

Data Source: A data request was submitted to the District of Columbia WIC program.

Note: This data reflects enrollment from 2009 to May 2010.

Source: Metropolitan Police Department, Washington DC
Criminal Justice Information System (CJIS) Arrest Data
Queried for CY 2008 vs 2009 by Race and Ethnicity

Note: CJIS data as of 06/29/2010 were queried. These totals include non-homicide arrest data. Totals are based solely on the top arrest charge. One person may be booked on more than one arrest charge. Excludes arrests for which no location could be identified between and of all arrests.
Please note that changes to MPD's PSA and District boundaries occasionally occur. The statistics above are based on
current police boundaries as of September 2, 2007.
For the purposes of the CJIS Arrest Report, the term "juvenile" used above is defined as individuals under the age of 18 years (= 17 years of age). These "juvenile" totals may include Title 16 cases where juveniles are tried as adults.The above non-homicide arrests reflect arrests made by all agencies in the District of Columbia.

Data Source:
Numerator: Data Request from DCPS Office of Data and Accountability (contact Hella Bel Hadj Amor) (n=1357)

Denominator: DCPS Webpage

http://dcps.dc.gov/DCPS/About+DCPS/Who+We+Are/Facts+and+Statistics

Data Source: U.S. Department of Health and Human Services Administration for Children and Families.

Table: Foster Care FY 2002 - FY 2008 Entries, Exits, and
Numbers of Children In Care on the Last Day of Each Federal Fiscal Year

Link: http://www.acf.hhs.gov/programs/cb/stats_research/afcars/statistics/entryexit2008.htm

Note:This table reflects State data submitted to the Children's Bureau as of October 9, 2009. The data also matches the numbers provided by the District of Columbia Child and Family Services Agency for FY 2009.

Narrative:
Notes - 2011
Source: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)

Single-parent families may include cohabiting couples and do not include children living with stepparents. Children who live in group quarters (for example, institutions, dormitories, or group homes) are not included in this calculation.

Total TANF enrollment as of December 31, 2008. Data provided by the District of Columbia Health Care Policy and Planning Administration. Please note that SCHIP data is not currently available by race/ethnicity.

Source: Supplemental Nutrition Assistance Program: Number of Persons Participating by State-January 2009. URL: http://www.fns.usda.gov/pd/29SNAPcurrPP.htm Accessed: May 6, 2009. //2011//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	38993	16768	36	2008
Percent in household headed by single parent	0.0	0.0	40.0	2008
Percent in TANF (Grant) families	0.0	0.0	11.0	2009
Number enrolled in Medicaid	0	0	164900	2009
Number enrolled in SCHIP	0	0	6307	2009
Number living in foster home care	0	0	2217	2009
Number enrolled in food stamp program	0	0	99203	2009
Number enrolled in WIC	0	0	4949	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2.7	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	9.5	2009

Notes - 2011
Data Source: U.S. Census Bureau-American Community Survey 1-Year Population Estimates-2008

Table: Age by Sex
Link: http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=04000US11&-context=adp&-ds_name=ACS_2008_1YR_G00_&-tree_id=308&-_lang=en&-_caller=geoselect&-format=

Data Source: Kids Count Data Center-District of Columbia
Table Title: Children in Single Parent Families by Race
Link:
http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=DC&cat=402&group=Category&loc=10&dt=1%2c3

0.0 Means 0. All persons were counted as "Ethnicity not reported"
We cannot change how 0 is reported here. It is automatically entered.

Data Source: This data was provided by Brian Campbell, Special Assistant in the District of Columbia Department of Health Services Income Maintainance Administration. The data was abstracted by Mr. Campbell from ACEDS.

Actual Number: The actual number of participants in 2009 was 16,110.

0.0 Means 0. All persons were counted as "Ethnicity not reported"
We cannot change how 0 is reported here. It is automatically entered.

Data Source: The Kaiser Family Foundation's State Health Profile: District of Columbia-2008

Link: http://www.statehealthfacts.org/profileglance.jsp?rgn=10&rgn=1

0.0 Means 0. All persons were counted as "Ethnicity not reported"
We cannot change how 0 is reported here. It is automatically entered.

Data Source: The Kaiser Family Foundation-Monthly CHIP Enrollment-District of Columbia
Link: http://www.statehealthfacts.org/profileind.jsp?nd=236&cat=4&rgn=10&cmprgn=1
Note: The data is a cross sectional monthly enrollment average.

0.0 Means 0. All persons were counted as "Ethnicity not reported"
We cannot change how 0 is reported here. It is automatically entered.

Data Source: This data was provided by Brian Campbell, Special Assistant in the District of Columbia Department of Health Services Income Maintainance Administration. The data was abstracted by Mr. Campbell from ACEDS.
Actual Number: The actual number of participants in 2009 was 99203.

0.0 Means 0. All persons were counted as "Ethnicity not reported"
We cannot change how 0 is reported here. It is automatically entered.

Data Source: A data request was submitted to the District of Columbia WIC program.

Note: This data reflects enrollment from 2009 to May 2010.

0.0 Means 0. All persons were counted as "Ethnicity not reported"
We cannot change how 0 is reported here. It is automatically entered.

Source: Metropolitan Police Department, Washington DC
Criminal Justice Information System (CJIS) Arrest Data
Queried for CY 2008 vs 2009 by Race and Ethnicity

Note: CJIS data as of 06/29/2010 were queried. These totals include non-homicide arrest data. Totals are based solely on the top arrest charge. One person may be booked on more than one arrest charge. Excludes arrests for which no location could be identified between and of all arrests.
Please note that changes to MPD's PSA and District boundaries occasionally occur. The statistics above are based on
current police boundaries as of September 2, 2007.
For the purposes of the CJIS Arrest Report, the term "juvenile" used above is defined as individuals under the age of 18 years (= 17 years of age). These "juvenile" totals may include Title 16 cases where juveniles are tried as adults.The above non-homicide arrests reflect arrests made by all agencies in the District of Columbia.

0.0 Means 0. All persons were counted as "Ethnicity not reporrted"
We cannot change how 0 is reported here. It is automatically entered.

Data Source: Public School Graduates and Dropouts From the Common Core of Data, U.S. Department of Education, National Center for Education Statistics.

Link: http://nces.ed.gov/ccd/pub_dropouts.asp

0.0 Means 0. All persons were counted as "Ethnicity not reporrted"
We cannot change how 0 is reported here. It is automatically entered.

Data Source: U.S. Department of Health and Human Services Administration for Children and Families.
Table: Foster Care FY 2002 - FY 2008 Entries, Exits, and
Numbers of Children In Care on the Last Day of Each Federal Fiscal Year
Link: http://www.acf.hhs.gov/programs/cb/stats_research/afcars/statistics/entryexit2008.htm

Note:This table reflects State data submitted to the Children's Bureau as of October 9, 2009. The data also matches the numbers provided by the District of Columbia Child and Family Services Agency for FY 2009.

0.0 Means 0. All persons were counted as "Ethnicity not reported"
We cannot change how 0 is reported here. It is automatically entered.

Narrative:
/2011/ The reporting year data is dependent on the data source. Data sources often lag 2 years behine the reporting year, such as all children 0-19 and percent in household headed by a single parent. 2009 data is reported from DHCF, WIC programs and DC Department of Corections.

Programs in place include:
1) Health insurance: Medicaid, Medicare and Alliance programs. Children are assigned a primary care provider as well as efforts to ensure all have a medical home.

2) WIC provides food and nutrition services.

3) Outreach and case management subgrants to address youth violence an dtruancy.

4) Collaborate with DC public and charter schools to address the health needs of youth, including drop outs and truant youth.//2011//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	145288
Living in urban areas	145288
Living in rural areas	0
Living in frontier areas	0
Total - all children 0 through 19	145288

Notes - 2011
Source: US Census Bureau-American Community Survey

Link: http://factfinder.census.gov/servlet/ADPTable?_bm=y&-context=adp&-qr_name=ACS_2008_3YR_G00_DP3YR5&-ds_name=ACS_2008_3YR_G00_&-tree_id=3308&-redoLog=true&-_caller=geoselect&-geo_id=04000US11&-format=&-_lang=en

Source: US Census Bureau-American Community Survey

Link: http://factfinder.census.gov/servlet/ADPTable?_bm=y&-context=adp&-qr_name=ACS_2008_3YR_G00_DP3YR5&-ds_name=ACS_2008_3YR_G00_&-tree_id=3308&-redoLog=true&-_caller=geoselect&-geo_id=04000US11&-format=&-_lang=en

The District of Columbia has no rural areas.

The District of Columbia has no frontier areas.

Narrative:
/2011/ The reporting year data is dependent on the data source. Data sources often lag 2 years behind the reporting year, such as all children 0-19 and percent in household headed by a single parent. 2009 data is reported from DHCF, WIC programs and DC Department of Corrections.

Programs in place include:
1) Health insurance: Medicaid, Medicare and Alliance programs. Children are assigned a primary care provider as well as efforts to ensure all have a medical home.

2) WIC provides food and nutrition services.

3) Outreach and case management subgrants to address youth violence an dtruancy.

4) Collaborate with DC public and charter schools to address the health needs of youth, including drop outs and truant youth.

5) Due to health disparities of children and adults DOH and its collaborative partners provide extensive outreach, education and other culturally competent services to those at-risk. //2011//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	591833.0
Percent Below: 50% of poverty	7.0
100% of poverty	10.0
200% of poverty	16.0

Notes - 2011
Source: US Censu Bureau-American Community Survey
Table: ACS Demographic and Housing Estimates

Link: http://factfinder.census.gov/servlet/ADPTable?_bm=y&-context=adp&-qr_name=ACS_2008_3YR_G00_DP3YR5&-ds_name=ACS_2008_3YR_G00_&-tree_id=3308&-redoLog=true&-_caller=geoselect&-geo_id=04000US11&-format=&-_lang=en

Source: US Census Bureau-Community Population Survey Table Creator Tool

Link:http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census Bureau-Community Population Survey Table Creator Tool

Link:http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census Bureau-Community Population Survey Table Creator Tool

Link:http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Narrative:
/2010/ The impact of current programs is unavailable at this time. /2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	145288.0
Percent Below: 50% of poverty	10.0
100% of poverty	14.0
200% of poverty	18.0

Notes - 2011
Source: US Census Bureau-American Community Survey 1-Year Estimates for the District of Columbia-2008

Table: Age by Sex

Link: http://www.census.gov/acs/www/SBasics/acs_2010.htm

Source: US Census Bureau-Current Population Survey Table Creator Tool- 2008 District of Columbia Data.
Link: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census Bureau-Current Population Survey Table Creator Tool- 2008 District of Columbia Data.
Link: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census Bureau-Current Population Survey Table Creator Tool- 2008 District of Columbia Data.
Link: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Narrative:
/2010/ Statistics are the same at 2009 because data is from 2007. The impact of current programs is unavailable at this time. //2010//

F. Other Program Activities

Lead Program
With newly enacted comprehensive lead legislation, the DDOE Lead Program performed

proactive lead inspections in order to identify lead problems and have them remediated, prior to a child being exposed to lead. In the event of elevated blood lead levels (5 -10 ug/dL) DDOE tests the child's home for the source of the lead. DDOE collaborates with CHA and DHCF to monitor these children at risk before their levels reach 10ug/dL.

A summary of the 2010 activities:

Family Voices of DC (FVDC) and CSHCN
CHA collaborates with Family Voices, an organization that is affiliated with the national Family Voices network whose mission is to "achieve family-centered care for all children and youth with special health care needs and or disabilities." Through its national network presenting 50,000 families of children with special health care needs, and Family to Family agencies in fifty states and the District of Columbia, it provides families with tools to make informed decisions about services for their children, advocate for improved public and private policies, build partnerships among professionals and families and serve as a trusted resource for families on therapeutic and health care decisions. FVDC is integral in the CSHCN Advisory Board and a partner in the transition program with National Alliance to Advance Adolescent Health.

The National Alliance to Advance Adolescent Health collaborates with the Department of Medicine George Washington University Medical Center, the Department of Community and Family Medicine of Howard University Medical Center, Adams Morgan Children's Health Center, Mary's Center, HSCSN, Family Voices-DC and national partners at Healthy and Ready to Work and the Center for Medical Homes Improvement collaborate with CHA to provide leadership in implementing the core transition outcome to achieve continuity within the medical home model of care between pediatric and adult health care systems.

The Oral Health Program has partnered with Howard University School of Dentistry, Children National Hospital Center dental Pediatric Residency program and St Elizabeth's Hospital Dental General Practice Residency Program to provide clinical rotation sites to the school based oral care. This provides an opportunity for residents and dental hygiene students to develop their clinical skills as well as enhance their cultural competency. The primary challenges in providing oral health services is securing permission from parents.

The Program continues its support to allow non-dental health providers to administer fluoride varnish to children during ESPDT visits. The Program objectives for 2010 include: expand fluoride varnish and dental sealant programs in DC schools; expand fluoride varnish and dental sealant programs in DC schools; establish an oral health network to develop local solutions to access to care problems; augment the partnership with Howard University Dental School to recruit and train oral health practitioners to provide services in schools including Head Start programs; improve the ability to collect epidemiological surveys, and data collection, tracking and evaluation of oral health services and programs.

CYSHCN Statewide Symposium - The CHA awarded a sub grant to Georgetown University to plan and convene a 1-day meeting of key stakeholders in creating/improving a system of care for CYSHCN in DC. These focus groups and key informant interviews will be used to begin the framework for the CYSHCN State Plan and will also be used to help guide the discussions during the Symposium, particularly in the afternoon sessions which will focus on starting the process of developing strategies to address the challenges highlighted. Georgetown University will also receive a sub grant to develop a District-wide Parent Advocacy Network with the aim of training and educating parents and families of CYSHCN to become Parent Leaders to encourage them to be advocates for children in their communities, become engaged as community activists, and assist other parents to do the same things.

Medical Homes Pilot -- CHA awarded a sub-grant to Children's National Medical Center (CNMC) to develop and implement a medical homes initiative in two of its sites. This initiative will utilize parent navigators (who are also parents of CYSHCN) to help other families navigate the health

care system.

Improving the Life of Special Needs Children: Transitioning from Pediatric to Adulthood -- CHA awarded a sub grant to the National Alliance to Advance Adolescent Health to conduct an analysis of the challenges faced by Youth with Special Health Care Needs as they transition to adulthood. T he Alliance convened focus groups consisting of both youth and families.

Development of Three New School Health Clinics
The DC Assembly on School Health Care (DC Assembly) is a coalition of organizations and individuals committed to providing quality and accessible health care for children and adolescents in the District of Columbia. The DC Assembly was founded to provide coordinated efforts to increase the availability of health care for at-risk and medically underserved populations through partnerships involving schools and health care providers. The goals of the DC Assembly included: 1) Establish sustainable school-based health care programs at 10 sites in the District by 2010; 2) Establish the DC Assembly as the policy leader for school-based health care in DC; 3) Establish strategic relationships with other groups, agencies, and associations to develop a clear delineation of roles and responsibilities for advocacy and support of SHCs in DC; 4) Work with City leaders to pass legislation and regulations to establish a funded and integrated SHC program; 5) Secure approval of Medicaid funding for child health services delivered in SHCs; and 6) Establish organizational capacity to support an ongoing program of policy development, advocacy, school recruitment, provider recruitment, and technical assistance for school-based health care programs.

Summer Camp - CHA awarded sub grants to summary camps: they include: Camp Happy Lungs through UMC/Breathe DC (asthma, respiratory disorders); Camp Round Meadow through HSCSN Inc.(respite camp for CSHCN); Fitness for Health Kamp for Kids, (Sensory/GrossMotor Camp) and Associates for Renewal in Education ARE Therapeutic Camp (behavioral/emotional needs camp).

An attachment is included in this section.

G. Technical Assistance

CHA did not request technical assistance from HRSA for the 2010 grant year.
The technical assistance needs for the 2011 grant year include:
1 Developing strategies to evaluate child deaths in DC due to intential injuries, suicide, suicidal ideation, and homicide.
2 Evaluate service and program capacity for children with special health care needs and their parents/caregivers.
3 Assistance with the development of a Youth Action Plan.
4 Develop strategies to implement the Katy Beckett waiver for emergency care funding for DC residents who
would not otherwise qualify for Medicaid.
5 Assistance to strengthen the cultural awareness and competence of CHA staff, and subgrantees and their programs.
6 Identify and develop data integration strategies.
7 Assessment of prevalence of subpopulations of CYSHCN and their experience with care in the district.
An attachment is included in this section.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	7061969	7061969	7067825		7066666	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	5288000	5288000	5300869		5300000	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	5313545	5313545	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	17663514	17663514	12368694		12366666	
8. Other Federal Funds *(Line10, Form 2)*	22682738	22682738	27493013		34532848	
9. Total *(Line11, Form 2)*	40346252	40346252	39861707		46899514	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	190550	1460000	1360738		1460000	
b. Infants < 1 year old	190550	737276	1360738		500000	
c. Children 1 to 22 years old	8208860	8605868	4474749		5406666	
d. Children with	2118591	2710779	2120348		2300000	

Special Healthcare Needs						
e. Others	3934029	3692742	2345339		2350000	
f. Administration	3020934	456849	706782		350000	
g. SUBTOTAL	17663514	17663514	12368694		12366666	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	140000		105000		105000	
d. Abstinence Education	0		0		0	
e. Healthy Start	3700000		3700000		3700000	
f. EMSC	0		0		0	
g. WIC	15907132		18787263		20431486	
h. AIDS	0		0		0	
i. CDC	2835606		4800750		8940362	
j. Education	0		0		0	
k. Other						
Project Launch	0		0		850000	
State Implementation	0		0		300000	
TBI	0		0		106000	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	2118591	2118591	2120348		2300000	
II. Enabling Services	4175035	4175035	3106163		3688881	
III. Population-Based Services	8348894	8348894	5445451		4861330	
IV. Infrastructure Building Services	3020994	3020994	1696732		1516455	
V. Federal-State Title V Block Grant Partnership Total	17663514	17663514	12368694		12366666	

A. Expenditures

/2011/ Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.

The FY2010 Award $ 7,091,016

The percentage of FY010 earmarking requirements included:

30% children with special health care needs: $ 2,120,000

YTD Personnel Services $ 716,976
YTD Non personnel services $ 456,875

Total expenditures $ 1,173,851

Earmarking requirements 30%

30% FY2010 Preventive and Primary Care Earmarking $ 2,120,000

YTD Personnel Services $ 316,779
YTD Non personnel services $ 267,144
Total expenditures $ 583,923

Earmarking requirements 30%

10% Administrative threshold $709,101

YTD FY10 expenditures on administration $ 350,000
% of FY10 Administrative threshold 4.9528 % //2011//

B. Budget

/2011/ The DOH allocates Title V funding according to the defined categories described in the Application Guidance: 30% for preventive and primary care services for children; 30% for services for children with Special Health Care Needs; 30% for planning, administration, evaluation and education; and 10% for grant administration. The following presents the budget narrative to support personnel; programmatic and other related expenses for 2010.

Personnel Budget Narrative $4,190,378
The proposed personnel budget includes program, administrative and support staff positions described below. The total salary cost is $4,190,378 and includes fringe benefits (.1794). The total personnel budget is $ 4,190,378, supporting 61.5 FTEs.

Title V fund allocation for staff is limited to the Administration, Perinatal and Infant Health Bureau, and Child, Adolescent and School Health Bureau.

Chief, Office of Grants Management
Administrative Officer
Epidemiologist
Executive Assistant
Grants Management Specialist
Program Analyst
Program Specialist
Project Coordinator
Public Health Advisor
Public Health Analyst
Receptionist
Statistical Assistant

Non Personnel Budget Narrative - $2,900,638

CHA proposes the following funding allocations to support the objectives of the Title V grant.

1) Allocate up to $400,000 for evidence-based Teen Pregnancy Prevention Programs
Enhance evidence-based programming to reduce teen pregnancy
2) Allocate up to $100,000 for a Childhood Obesity Prevention/Breastfeeding Promotion imitative to create Baby-Friendly Hospitals in DC
Supplement local and other federal funds to reduce childhood obesity.

3) Allocate up to $200,000 to address mood, emotional, developmental or cognitive disorders and prevent intentional injury These funds should be used to enhance capacity for and access to services for children and youth with mood, emotional,
developmental or cognitive disorders and their families.
4) Allocate up to $250,000 for a Pediatrics-to-Adult Transition Program to improve coordination of care for CYSHCN - The program is expected to support the transition of children with special health care needs from pediatric to adult services through a case management program.
5) Allocate up to $250,000 for a Parent Information Network - The scope of work will include expansion of navigation services to families with children with special needs; provision of referrals to parent support, home education, and parent skills training; development of a resource directory of state and regional services for children with special health care needs; leadership training for parents/caregivers; and cultural competency training for providers.
6) Allocate up to $200,000 for Pediatric Asthma Control
Enhance capacity for and access to services for children and youth with asthma and their families.
8) Allocate up to $150,000 for Sickle Cell Disorder
Enhance capacity for and access to services for children and youth with sickle cell disorder and their families.
9) Allocate up to $1,000 to pay for up to 3 members of the CSHCN Advisory Board to attend the AMCHP conference. CHA will determine eligibility based on need and willingness to provide presentations to the advisory board.
10) Allocate up to $30,000 for Title V Staff Training used to support the professional development of program staff.
11) Allocate up to $33,750 for OCTO to provide information technology maintenance services includes help desk support and trouble shooting for technology issues. Costs are estimated at $750 per year time for an estimated 50 personal computers.
12) Allocate up to $200,000 for enabling services to increase access to quality health care for children, youth and children/youth with special health care needs.
13) Allocate up to $100,000 to continue the Family Navigation program, including transition of web site.
14) Allocate up to $200,000 for Prevention of Sexually Transmitted Infections Among Youth
Enhance capacity for and access to preventive and treatment services for sexually transmitted infections among youth
15) Allocate up to $100,000 for Oral Health
Enhance capacity for and access to oral health services for children and youth

Any additional funds will be used to cover emerging priorities and unanticipated expenses.
Maintenance of Effort/State Match
The District of Columbia expended $6,148,876 in state funds in providing services to the Title V population. This amount is $860,876 in excess of the $5,288,000 MOE requirement and $860,876 in excess of the $5,300,000 state match requirement. The MOE and matching funds are used to provide nursing services to all students attending District of Columbia public and public charter schools.//2011//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.